PUBLIC HEALTH NURSING

JULY
1949

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PUBLIC HEALTH NURSING

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BIENNIAL IS NOT FAR AWAY

THE DAYS pass quickly, months seem to run away from us. Before too long—in just ten months—another biennial nursing convention will be held. Now is the time to plan to be present when the roll is called early in May 1950 in San Francisco. All kinds of plans need to be made. First, and not of least importance, is money. A lot of us will get to California next May only if we budget for it. Let's do some work with pencil and paper and make a sensible arrangement of systematic saving for this purpose. Maybe vacations next spring will be in great demand. Now is the time to place a priority bid for a May vacation. Maybe it will be possible to adjust holiday time so that a few extra days will be available for seeing the glories of the West.

And yet the opportunity to travel, to see historical monuments, romantic places, is only secondary to the opportunity to participate in the 1950 nursing convention. For this will truly be a time of decision. Assuredly in 1950 the nursing profession must come finally to grips with the subject of structural reorganization. There have been several years for planning, for discussing, for evaluating. Now the deciding vote must be cast. Of course there will be the need for last-minute discussion, and adequate time at the convention must be assigned. But the action that is called for is *decision*. You will be needed. Will you be there?

Individuals have to plan for time and money. The national organizations, in addition, have the responsibility of planning for all the behind the scenes activities necessary for the smooth running of events and the comfort of participants. The program committee carries heavy responsibilities. The NOPHN, ANA, and NLNE each has a program committee which together form the Joint Program Committee. Meetings of all these will be held soon.

The NOPHN invites its members to send suggestions and ideas about the program they would like to see developed for the convention. The 1950 convention theme has not yet been selected. Ten years ago the theme was Nursing in a Democracy. During ensuing years, convention programs reflected the wartime emergency. There are major issues today that affect all nurses and all nursing services. There are problems of basic concern to groups and to individuals. Can you suggest a theme, a program built on deliberation on these topics?

The NOPHN program committee wants to know what public health nurses are thinking about and what questions they would like discussed in open session. This can be made the most dynamic nursing convention of our time, if it means enough to you and you and you. As a vital part of the NOPHN will you let your committee know what concerns you at this time. The program committee is ready to consider your recommendations. It is up to you to speak now.

SHALL WE TEACH THEM ALL TO FLY?

MARY ELLA CHAYER, R.N.

ONCE UPON a time, so runs a modern legend, the animals of the forest decided that they would start a school in which all training would be standardized. They thought this a good idea, in order to eliminate competition, rivalries, and quarreling. As a requirement for all students a basic training program was set up by a group of experts, which consisted of running, jumping, climbing, swimming, and flying.

To this school came animals from forest, field, and stream—among them a delightful personality, Master Squirrel. In the flip of a squirrel's tail he became the darling of both students and faculty because of his feats of daring combined with a playfulness which was a delight to all. He could run and jump and climb, and when he had to he could swim, though he wasn't so crazy about swimming.

Only in one class was his progress unsatisfactory: the squirrel couldn't fly! Strangely enough he *thought* he could fly. In fact he thought he *was* flying as he took off from the top of a tall tree and gracefully sailed through the air making a perfect (so he thought) landing. But "No" said the instructor. "That is not flying. It is not flying at all, for it does not meet any of the three criteria for flying. First you lose altitude, second you don't start from the ground, and third you do not take off into the wind."

Now this squirrel had a profound respect for his elders and an urge to succeed in meeting whatever criteria were enunciated by his betters. He also had an insatiable curiosity and a contagious enthusiasm. With all of this equipment he tried to act upon every suggestion of the experts, and practiced faithfully whether he was being watched or not. In fact, he dedicated his whole life to the task of learning to fly, subordinating all his other interests to this one objective. He spent day after long day taking his position from the ground and plunging into the wind as he was taught. But alas no matter how hard he tried he was unable to meet the standards of excellence enunciated by the school and reluctantly he was dropped from the roster.

This story has a sad ending, for while in school the squirrel had neglected all of the skills which hitherto had served him adequately in earning a living. And having lost all power to defend himself he fell an easy victim to predatory animals who had never been to school. Thus his brilliant career was quickly ended.

During his struggle for mastery of the air, the squirrel had, all unknowing, been under the eye of a wise old Coyote who was greatly disturbed over the failure of his young friend. "I believe you're doing this thing wrong end to." "What do you mean, wrong end to?" bristled the Dean. "Well, I'm no expert, but it seems to me your squirrel might have become the best runner and jumper in the forest, and your beaver over yonder, the best engineer in the dam-building business, if you see what I mean." "No, I don't see what you mean. How do you propose," said the Dean, "to

Miss Chayer is professor of nursing education, Teachers College, Columbia University.

cover the basic essentials?" "That," said the Coyote, "is for you experts to decide. I only lay down fundamental principles."

Controversy or Confusion?

"Every nurse a public health nurse." "Nursing is basically the same wherever it is practiced." "Every nurse should be able to function equally as well in one service agency as in another, at least on a staff level." "We are all community nurses." These and similar expressions are being used by the nurse in the hospital and in public health. To some they have taken on the nature of a campaign slogan, and anyone expressing a difference of opinion is denounced as ignorant and isolationist. What do they mean, these phrases so glibly used and defended?

Undoubtedly there are honest differences of opinion about the future directions which nursing should take. Those differences of opinion need clarification so that we may be sure just where our differences lie. The intent of this paper is to make an analysis of some of our points of agreement and of our points of difference. It is hoped that the views expressed here will be further analyzed by writers of succeeding papers until we can come to know clearly our points of agreement and difference. We will then be in a better position to make such compromises as are necessary in order better to serve the public.

Can We Agree Upon Basic Assumptions?

Public health nursing has been accepted, ever since its inception, as a specialized area of nursing service. This concept is now being challenged at a time when both nurses and the public are struggling with such concepts as "professional nursing," "registered nursing," "trained practical nursing," "nursing technician." It is fitting that in defining nursing for the future all aspects of service should be scrutinized. A few assumptions are here presented as a point of departure. If they are accepted as valid, we can then proceed to further analysis of the problem at hand.

1. Public health is conceived as a goal toward which all health personnel makes a contribution. All nurses are obligated, insofar as the position in which they are working permits, to contribute to the goal of public health in such areas as human growth and development, prevention of diseases and the care of the ill. The nurse in public health has *no priority* in these areas except that inherent in the situation in which she works. Her situation may offer greater opportunities for health promotion and disease prevention than is found in many hospital situations.

2. In all nursing and health care every nurse has an obligation to consider the social factors in family life and in the community which influence the health status and care of all members of the family of which the individual person is a part.

3. Professional nursing in the future will continue to be practiced in the home, the clinic, the health center, the school and the industrial establishment, even in the event that the "hospital health center" becomes a reality. Agencies employing nurses must be clear about the kind of preparation necessary for staff members.

4. There is a place for specialization in nursing whenever there is a body of specialized functions and skills needed in some situations and not needed in others, or when those functions and skills are so complicated or time consuming that their acquisition by all would be uneconomical.

5. There are persons who have greater aptitude for work in one field of nursing service than in another. Preparation for nursing should take into consideration differences in preference and aptitude.

6. A profession has an obligation to define lines of demarcation between specialization and generalization and to prescribe the preparation necessary for each type of specialty.

Are there honest differences in the functioning of nurses in different types of community agencies?

The hospital nurse says that she too considers the family as a whole while giving nursing care to an individual. She no longer believes that this is a prerogative of the nurse in public health. This is true of hospital nursing at its best. The nurse discovers every-

thing that she can about the family which will help her to give more intelligent and understanding care to her patient. She utilizes every opportunity to talk with family members and visitors. She utilizes the channels of communication available which result in continuity of care from hospital to home. How does this differ from the nurse in public health?

At best the nurse in the hospital considers the family *in absentia* while the nurse in public health actually goes to the home and *sits down* with the family. She is the guest and not the hostess. She has to utilize various technics in order that she may be an invited guest and not an intruder. In the event that her first visit is without the benefit of invitation she must manage her conference in such a way that her next visit is *desired* by the family, for her relationship must often be of a long-term nature involving the problems which may not be apparent to the family—problems of child growth and development, problems of nutrition, problems of geriatrics. Her need in the home is often not so spectacular as is the need of care in the acute illness situation commonly cared for in the hospital. She helps to detect early stages of illness or untreated chronic conditions, many of which have been accepted by the family as inevitable.

The nurse in the hospital needs no special technic in locating her patients. There they are every day waiting for her as she goes on duty. The nurse in public health needs to develop special technics of locating persons in need of medical and dental care and of persuading them to seek early and often long continued care for tuberculosis, syphilis, cancer, rheumatic fever, heart involvements, and the many other conditions needing attention. She finds the pregnant woman in those early months before nature has blatantly proclaimed its purpose to the world. She locates the slightly ailing child at school whose "syndrome" presents a pattern indicating the onset of some unsuspected condition. She recognizes the child with slight muscle disfunction and gets him under treatment for unsuspected poliomyelitis. She discovers the fearful person who is afraid to go to the doctor for fear he will tell her she has cancer or a heart condition. She explains to those persons in need of early treatment the means of avoiding more grave complications.

On the other hand, the nurse in the hospital needs technics for the care of the more acutely ill person which are not applicable to home care. To her an emergency is an everyday occurrence. She is easily able to summon at a moment's notice necessary equipment and personnel. To the nurse in public health an emergency is a challenge calling forth not only her finest powers of judgment, ingenuity, and initiative, but also great skill in improvisation and in securing not easily obtainable facilities.

The nurse in public health has a twenty-four hour responsibility for nursing care not shared by other nursing personnel. During the hour or two which she spends in the home she must anticipate future needs and teach some person in the home to carry on in her absence. Sometimes only a child is available and the nurse must explore familial and other community resources when hospitalization is not available. Her task is not only to tell people what to do, but also to teach them how and when to do; and give them opportunity to practice under her supervision.

As difficult as is the problem of teaching twenty-four hour nursing care, there is the infinitely more difficult and more complicated skill of helping people to change their habitual behavior in the interest of future health, and for the avoidance of unforseeable illness. These kinds of skills take many months to acquire. They cannot be learned in a day, or a week, nor can they be learned outside of the home.

The nurse in public health has a number of families for whose nursing care she is solely responsible whereas the nurse in the hospital shares these responsibilities with several other nurses.

No mention has yet been made of the special technics needed by the nurse acting as consultant to the personnel of public schools on behalf of the health of school children and teachers, and the unique contribution which she should make in helping the school define and achieve its health objectives. Nor has mention been made of the nurse who serves the industrial concern in the health

supervision of its employees. Nor yet the technics which a nurse needs who serves the rural community where no hospital facilities are available. She has often been called upon to organize the responsible citizens in the community to secure for themselves facilities which no individual working alone can procure for himself.

Is there still a place for specialization in nursing in public health?

The above examples of functions of the nurse in public health seem to indicate that there is a body of special skills which are utilized to a greater extent by the nurse in public health than by the nurse in the hospital. These skills are of such a nature that they need to be kept in constant practice in order to be called into play when needed most. Some of these skills are of such a nature that persons with special aptitudes function more easily than others in their performance. We find, therefore, persons who select the area of nursing in public health in preference to nursing in the hospital situation. The question now arises—does the concept of the hospital health center preclude the possibility of specialization in this field?

When a hospital becomes a health center is it likely that the nurse will don her white uniform in the morning, take care of a patient or two, then change to a colored uniform and rush out to take care of a family? What an absurdity! What then is likely to be the pattern of nursing administration in the hospital-health center unit? The chances are that selected staff nurses will be assigned to hospital service and others to service outside the hospital in the home, the school, or the industry, with possibly a middle ground where both groups meet in health center clinics. There might even be some interchange of staff, but it is difficult to see how a complete interchange of nursing staff would lend itself either to efficient administration or to improvement in nursing service inside or out of the hospital.

Will "professional nursing" make a difference?

Assuming that sooner or later all professional nurses will receive their education in an institution leading to a degree and that during this preparation students will have access to a far broader "clinical" field than is now provided within the walls of the hospital, how far will this experience go in preparing every nurse for the broad functions of the nurse in public health as well as those of the nurse in the hospital? Shall we teach them all to fly, or should there be some differentiation within the four years of professional education? Should special aptitude and preference play a part in determining the degree of specialization?

If we assume for the moment that it might be desirable for every student to have experience in public health agencies, then how much time should be devoted to this field?

A fairly typical program of professional education includes the following essentials for a Baccalaureate degree in nursing:

1. Literature and the language and communication skills, 15-18 points
2. The physical and biological sciences, 15-18 points
3. The social sciences, 15-18 points
4. The arts, 6-10 points

This leaves for introduction to nursing arts and all other clinical experiences about 60 points.

In the present public health nursing program some 40 points are devoted to theory and practice leading to preparation for first level positions in public health nursing. Undoubtedly some of this content could be reduced through a carefully integrated program of preventive and curative nursing experiences in the basic program. How far it can be reduced will depend largely upon the quality and quantity of field experiences available to students through community programs. Will these experiences be adequate in quality if the nurses in community service agencies have themselves received only a minimum of field experience?

There is also that question of sheer quantity. If all of the 20,000 nurses now engaged in public health nursing were to participate in the preparation of a minimum of 30,000 nursing students yearly from professional nursing schools, the task would seem almost, if not

altogether, insurmountable! In view of the fact that the primary purpose of the field agency is service to the public, how far can any service agency go in offering its facilities to educational institutions without jeopardizing the program to which it is basically committed? We must face these problems realistically in our planning for the future. What other alternative do we have?

Can nurses become resource persons to each other?

Does the answer possibly lie in some measure of differentiation of experience on the basis of aptitude and preference, with some persons proceeding far enough in one direction so that they may, with experience, become resource persons to others whose preparation has gone farther in some other direction? Let us look at an example: Suppose that a nurse interested in human behavior in all of its manifestations has elected to become more expert in psychiatric nursing than in any other field. When a patient is recovering to the point that he expects to go home soon, let us suppose that a nurse who is more expert in the field of public health is called in to see the patient while he is in the hospital. The two nurses work together, each as a resource person to the other in defining a plan of nursing care which will assure for the patient continued understanding, thus avoiding that period of bereavement suffered by many patients during the first months of separation from the hospital. Let us assume further that the nurse in public health further utilizes her hospital colleague as a resource person as problems of nursing care arise with these and other patients. Each nurse thus becomes more appreciative of the contribution of the other, yet each person is free to pursue her own major interests.

Old man Coyote says that if you work on the peaks of interest of your students the peaks will pull up the valleys far beyond the point of mediocrity.

RECRUITING NURSES AND PHYSICAL THERAPISTS DURING OUTBREAKS OF POLIO

In preparation for possible outbreaks of polio, the National Foundation for Infantile Paralysis has formulated plans for temporary nursing and physical therapy service. Two statements have been issued (1) Procedures for the recruitment of nurses for infantile paralysis, adopted by the NFIP and the American Red Cross and (2) Procedures for the recruitment of physical therapists, adopted by NFIP and the American Physical Therapy Association.

Local chapters of the National Foundation are responsible for bringing together the health officer, hospital administrator, "nurse coordinator," and chairman of the medical advisory committee or other representative of the local chapter, to determine the need for temporary nurses. The Red Cross does the actual recruitment. The nurse coordinator is to be appointed by the district nurses' association in each community that serves as a hospital center for polio patients. She will act as a liaison between recruited nurses and polio committees where they exist, the Red Cross chapter, hospital, and NFIP chapter. The statement on procedures further outlines policies in regard to in-service training, salary and hours of work, and maintenance of recruited nurses.

Physical therapists are to be recruited by the American Physical Therapy Association, 1790 Broadway, New York 19, at the request of the National Foundation's state representatives or chapter chairmen. Other details covered in the precedural statement concerning policies relating to physical therapist recruits have to do with interpretation of emergency, qualifications, employment, supervision, salary and hours of work, maintenance, and travel expense.

Either or both statements can be obtained on request from the National Foundation for Infantile Paralysis, 120 Broadway, New York 5.

COST OF LIVING: A DECADE OF CHANGES AND TRENDS

FRANKLIN B. CAFFEE

EVERYBODY has been talking rather freely about cost of living increases and seems to have very definite ideas on the entire question of the spiraling economy. Strangely enough, few people know the facts and the facts speak for themselves.

The Bureau of Labor Statistics figures show that the net spendable weekly earnings of production workers in manufacturing industries have risen 32 percent for workers with 3 dependents and 18 percent for workers with no dependents in the period from 1939 to January 1949 *after* correction for the rise in prices and taxes.[1] It is interesting to note what has happened to public health nursing salaries during this period.

Salary figures published in PUBLIC HEALTH NURSING, November 1939 for staff public health nurses in various types of official and nonofficial agencies indicate that the median annual salary of a field nurse was approximately $1,500 in December 1938.[2] But Bureau of Labor Statistics figures on the cost of living show a rise of 70 percent in consumer prices since this period.[3] Since the maximum federal income tax on a single person's salary of $1,500 in 1938 was $14,[9] a single person in March of 1949 must have available $2,536 in cash—after current federal income taxes have been deducted—to avoid a decline in purchasing power and the level of living. This would require an income for a single person of $2,900 on which the federal income tax is $350.

Mr. Caffee is public health representative, Public Health Service, Federal Security Agency, Region II, New York City.

EFFECT OF PRODUCTIVITY

Productivity in the United States is known to rise at an annual rate of somewhere between 2 and 3.5 percent.[4] The concept of productivity increase is based on the fact that output per man-hour tends to increase and unit labor costs tend to decrease in America due to constantly increasing technological efficiency. These economies are passed on to the public by means of price cuts and wage increases. Unless persons in the "service" fields, such as nursing, share in the gains made possible by the American economic system they will find themselves steadily losing ground to those groups which profit by the gains. In the 10 years from 1939 through 1948 an increase of 2 percent a year on a 1938 salary of $1,500 would be at least $300. This brings the comparable figure for the public health staff nurse who received $1,500 in 1938 up to a figure somewhat above $3,200 per year in 1949. (This is obtained from $1,500 plus 70 percent for increase in the cost of living, plus $350 tax, plus 20 percent for productivity benefits or 10 times 2 percent a year.)

COST OF LIVING INDEX

The cost of living trend is proved conclusively by Bureau of Labor Statistics data. These data show that the Consumers Price

Index reached a high point of 174.5 in August and September 1948, an increase of almost 75 percent, above the base period (1935 through 1939 equals the base 100.0).[6] After September 1948 the Index declined slowly for five months but rose fractionally in March 1949 to 169.5.[3,7] There is quite general agreement among economists that prices will not in the next decade or two fall to prewar levels, or anything like them. World War I price behavior gives some clues to probable long range trends of consumer prices. Using the same 1935-1939 base period as 100.0, the index in 1913 was 70.7.[4] (Table 1.) It rose to 143.3 in 1920, an increase of over 100 percent. During the next decade it never again fell below 119, and for the 10 postwar years after 1918 averaged about 75 percent above 1913.[4]

Suppose, however, that over the next few years prices fall and the Consumers Price Index drops from 169.5, which it was in March 1949, to 160. In order just to keep even nurses would have to have an increase in the minimum rate of pay for each class of position of at least 160 percent of the prewar rate. For staff nurses the $1,500 prewar salary would need to rise to $2,400. The figure of $2,400 would fall short of the necessary minimum salary needed to maintain purchasing power by about $300, due to income taxes now being collected.[8] Other groups have managed to push up their gross earnings more than enough to compensate for the rise in income taxes, as will be shown below.[1]

Taxes have not actually reduced the level of living of most Americans below the prewar level.[10] Per capita income rose 130 percent from 1940 to 1947. The national income rose from 70.6 billion in 1939 to 173.8 billion in 1947. "Real" spendable income—dollar income corrected for price changes—rose from 70.6 billion in 1939 to 109 billion in 1947.[10]

TABLE 1. CONSUMERS PRICE INDEX FOR MODERATE INCOME FAMILIES IN LARGE CITIES FOR SELECTED PERIODS, 1913-1948

1935-1939 = 100.0

PERIOD	INDEX
1913	70.7
1916	77.9
1917	91.6
1919	123.8
1920	143.3
1922	119.7
1926	126.4
1929	122.5
1933	92.4
1941	105.2
1943	123.6
1945	128.4
1947	159.2
1948	171.2
March 1949	169.5

SOURCE: Bureau of Labor Statistics, Handbook of Labor Statistics, 1947; and *Monthly Labor Review*, March 1949.

MINIMUM ADEQUATE BUDGETS

The Bureau of Labor Statistics and at least 12 state departments of labor,[11,12,13] the National Industrial Conference Board, and the Heller Committee for Research in Social Economics of the University of California,[14] have prepared lists of goods and services considered to be essential for the continuous maintenance of the minimum level of living of single persons or family groups. These budgets involve assumptions of various sorts about health, decency, adequacy, self-respect, et cetera. For a single woman living alone they tend to price at somewhat over $2,000 in 1948. For example, the Heller Committee's budget for a single woman in San Francisco priced at $2,217 in September 1948.[14] The New York State Department of Labor, Division of Industrial Relations, Women in Industry and Minimum Wage Budget, priced at $2,109 in New York City in September 1948.[13] However, the New York budget was for a woman living as a part of a family group. The New York budget for women living alone in the years 1937-1940 priced at least 10 percent above budgets for women living in family groups.[15]

The Study of the Economic Status of Registered Professional Nurses 1946-1947, made by the Bureau of Labor Statistics in cooperation with the National Nursing Council, points out that the supply of young women entering nursing schools is inadequate because of the fact that the pay of nurses so closely parallels the pay of women employed in jobs requiring no special preparation.[16] Women general stenographers averaged $43.37 per week in New York City in January 1948, an annual salary of $2,255.[17] Markets are

TABLE 2. RELATIVE DIFFERENCES IN THE COST OF GOODS, RENTS, AND SERVICES IN 34 CITIES, JUNE 1947 AND MARCH 1946.

Washington, D. C. = 100

CITY	TOTAL COST OF GOODS AND SERVICES	
	June 1947	March 1946
Atlanta, Ga.	92	91
Baltimore, Md.	95	94
Birmingham, Ala.	93	93
Boston, Mass.	96	96
Buffalo, N. Y.	90	89
Chicago, Ill.	95	94
Cincinnati, Ohio	91	91
Cleveland, Ohio	93	92
Denver, Colo.	92	92
Detroit, Mich.	96	95
Houston, Tex.	88	86
Indianapolis, Ind.	90	90
Jacksonville, Fla.	91	91
Kansas City, Mo.	88	88
Los Angeles, Calif.	94	92
Manchester, N. H.	91	91
Memphis, Tenn.	94	93
Milwaukee, Wis.	96	95
Minneapolis, Minn.	95	94
Mobile, Ala.	94	94
New Orleans, La.	88	88
New York, N. Y.	97	95
Norfolk, Va.	94	94
Philadelphia, Pa.	92	90
Pittsburgh, Pa.	96	93
Portland, Maine	93	92
Portland, Oregon	92	93
Richmond, Va.	93	94
St. Louis, Mo.	94	95
San Francisco, Calif.	95	95
Savannah, Ga.	92	92
Scranton, Pa.	92	89
Seattle, Wash.	98	98
Washington, D. C.	100	100

SOURCE: Workers' Budgets in the United States, 1946 and 1947. Bulletin No. 927, U. S. Dept. of Labor, Bureau of Labor Statistics, page 23, Table 2.

impersonal and charge one price to all customers. Professional people when purchasing housing, food, clothing, recreation, et cetera, compete with all other consumers.

GAINS IN OTHER FIELDS

The warborn shortage of labor plus the shift of the labor force away from low paid service industries into higher paid manufacturing industry caused spectacular boosts in wages.[4,5] Gross average weekly earnings of production workers in manufacturing industry rose from $23.86 in 1939 to $55.03 in December 1948, a rise of 131 percent.[1] Net spendable average weekly earnings—cash take-home pay after deductions for Social Security and income taxes—for a worker with 3 dependents rose from $23.62 per week in 1939 to $53.92 per week in December 1948. This is an increase of 128 percent. For the worker with no dependents the increase would be from $23.58 in 1939 to $48.18 in December 1948, or 104 percent.[1]

The above figures show both gross weekly wages and net cash take-home pay. By correcting the December 1948 figures to the extent of the rise in prices since 1939, the degree to which both workers with 3 dependents and single workers are ahead of the inflation spiral is shown. Their "real" wages —purchasing power—have risen in spite of price rises. December 1948 net spendable average weekly earnings of $53.92 and $48.18 when converted to 1939 dollars give equivalent figures of $31.27 and $27.94.[1] Therefore an individual with 3 dependents has increased his "real" wages from the actual 1939 net spendable figure of $23.62 to an equivalent figure in December 1948 of $31.27 in terms of 1939 prices. A single person has increased his actual 1939 average net spendable weekly earnings of $23.58 to an equivalent figure of $27.94 in terms of 1939 prices.[1] These increases in net spendable average weekly earnings amount to 32.4 percent for a person with 3 dependents and 18.4 percent for a single person.

Contrast these gains of production workers in manufacturing industry with the losses suffered by white collar and professional workers in the last 10 years. For instance, the staff public health nurse received an average salary of about $1,500 in December 1938. In 1947 this was about $2,200.[2,18] The survey made by the Bureau of Labor Statistics found the median salary of public health nurses to be $184 per month in October 1946.[16] This is $2,208 per year, or less than 50 percent above the 1939 salary of $1,500.[18] Later studies by the Public Health Service in cooperation with the American Public Health Association and the State and Territorial Health Officers Association found that the median salaries of local public health staff nurses were between $2,400 and $2,520

in May 1948, and that the median range for field nurses in the state health departments in August 1948 was $2,400 to $2,500.[19,20] The federal income tax cuts a salary in this range by about $260 to $275 per year for a single person with no dependents.[8]

GENERAL CONSIDERATIONS

The alleged differential in the cost of living between large and small communities and among regions of the country has tended to confuse and obscure the simple issue of adequate pay. The Bureau of Labor Statistics has made very careful computations of differences in the cost of achieving the same level of living in various geographical areas and in cities of varying sizes.[21] Its city workers family budget was priced in 34 cities in March 1946 and in June 1947 and the money totals converted into index numbers.[21] Table 2 shows that in June 1947 there was a maximum difference in prices of 12 percent between the highest priced city and the lowest. It also shows that the difference in prices was 6 percent or less in 44 percent of the cities and 8 percent or less in 76.5 percent of the cities. The budget totals do not vary consistently either with size of city or with geographic area. The relative position of the cities in the cost scale does not remain fixed even over a 15-month period. These figures indicate that wage differentials between areas or cities of differing size are not justified by the facts.

The New York State Department of Labor has prepared a minimum adequate budget for single women.[13,22] This budget priced in September 1948 at $2,109 in New York City and $2,040 in the upstate cities and towns.[13] (Table 3.) This is a difference of only 3.3 percent and would not justify a wage differential in upstate New York State. The alleged attractions of the big city might even tend to force upstate areas to offer higher salaries than New York City in order to attract scarce, trained, professional personnel.

In New York City the Consumers Price Index for March 1949 was 167.4 percent of the 1935-1939 average.[3] The comparable Memphis, Tennessee, index was 173.3. This does not mean that prices were higher in Memphis than in New York City in March 1949. It means that prices have risen a greater percentage in Memphis than in New York City since the base period (1935-1939 equals 100.0). Therefore workers in Memphis need a larger percent increase over their 1939 salaries than do those in New York in order to compensate for the price rise.

TABLE 3. ANNUAL COST OF ADEQUATE MAINTENANCE AND PROTECTION OF HEALTH FOR A WORKING WOMAN LIVING AS A MEMBER OF A FAMILY, NEW YORK STATE, SEPTEMBER, 1948[1]

New York State	$2,087
New York City	2,109
Upstate	2,040
Population of 10,000 and over (except New York City)	
Buffalo	2,046
Rochester	2,050
Schenectady	2,083
Poughkeepsie	2,084
Cortland	2,021
Population of 1,000 and under 10,000	
Norwich	2,016
Carthage	1,989
Gowanda	1,948
Wayland	1,962
Cuba	1,907

[1] These figures must be reduced a few dollars because the State Income Tax was computed on a 100% basis instead of the approximately 89% figure actually collected.

SOURCE: Special Labor News Memorandum, Number 13, January 31, 1949, page 3. State of New York, Department of Labor, Division of Research and Statistics.

The Federal Government has led the way in recognizing that professional nurses are entitled to professional pay. In 1939 the public health staff nurses were paid $1,800 per year and classified as SP-5—the subprofessional series. In 1946 staff nurses were reallocated to the P-1 grade, the trainee grade for professional classes in the federal service, which pays $2,975 to start, and rises to $3,727 after six years of satisfactory service.

Because prices have fallen a little it should not be considered that the salary question is solved. Steadily for 10 years nurses' salaries have lagged behind the upturn in prices. It is quite fitting and proper that their salaries should catch up now, and then later perhaps remain stable, even if prices decline somewhat. As pointed out above, prices declined

only 3.2 percent in five months, October 1948 through February 1949. This decline was halted in March 1949 by a rise of 0.5 in the index. Rents are rising steadily and will tend to keep the index up.

The safeguarding and improvement of the economic status of nurses is one of the most practical methods of attracting an adequate supply of high calibered young people into the profession of nursing.

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THE 26-nation executive board of the United Nations International Children's Emergency Fund met in Paris on June 27 to make plans to carry the Fund's operations through June 1950. The United States has appropriated a total of $100,000,000 toward the Fund which must be matched by other governments on the basis of $2.57 U. S. money for every $1 from other sources. Approximately $40,000,000 is still available from the U. S. if the other governments contribute $16,000,000, which amounts would carry the Fund through the year 1949-50. The Fund is currently feeding or partially feeding 4½ million children in Europe, and in addition supplying medical supplies and assistance to children in Europe, Southeast Asia, and the Far East.

EXTENDING HOSPITAL CARE TO THE HOME

HORTENSE HILBERT, R.N.

IN NOVEMBER 1948 the Bureau of Public Health Nursing of the New York City Health Department began, on an experimental basis, to provide home nursing to patients transferred from a municipal general hospital in one of our five boroughs. The other four city hospitals at present selected for home care of transferred patients are similarly served by two voluntary public health nursing agencies, the Visiting Nurse Service of New York and the Visiting Nurse Association of Brooklyn.

The possibility of future increased responsibility on the part of health departments for home care of the sick as the result of greater development in public medical care, voluntary and contributory health insurance, and other cooperative plans is quite generally foreseen. Hence the Bureau of Public Health Nursing saw the home care program of another department of the city government as a further opportunity for testing the feasibility of adding care of the sick to a general public health nursing service.

Factors which influenced our decision to do so were that the number of patients transferred could be controlled; the health department centers in the borough served by this hospital had achieved a considerable degree of "readiness to serve" in that a general public health nursing service relatively broad in scope was already in operation; and development of closer working relations between hospital and public health agency to improve care of the sick was greatly desired.

The lessons to be learned from caring for patients transferred from hospital to home it was thought would supplement and augment the experiment in another health center district, where the Brooklyn Visiting Nurse Association and the Bureau of Public Health Nursing of the New York Department of Health had joined forces two years ago to offer the community a completely general public health nursing service.*

Health Department nursing personnel was increased in the borough here in question, and in-service training in home nursing was provided to all public health nurses before this care was offered. Systematic liaison was established through the appointment by the Department of Hospitals of a nurse consultant in home care to its central office and to the hospital.

Since both the departments of hospitals and health are branches of the same government, fees for service do not enter into the arrangement as they do in case of a voluntary public health nursing service.

Medical and all other services besides pub-

Miss Hilbert is director, Bureau of Public Health Nursing, New York City Health Department.

* Dickson, Mrs. Carroll J., and Hortense Hilbert. Streamlining a community nursing service. PUBLIC HEALTH NURSING, v. 38, November 1946, p. 598-607.

lic health nursing which are available to transferred patients are and will be supplied by the Department of Hospitals. These include assistance from practical nurses assigned to the public health nursing staff though employed by the hospital; nutritional, occupational, and physical therapy services; some housekeeping; and case work through the department of social service. Medications and supplies, appliances and equipment are also made available as needed.

The services given by Health Department nurses follow the customary pattern of home care of the sick whether given under the medical direction of the physician in private practice or clinic, or to patients discharged from hospitals. Instruction, family health guidance, and teaching household members to give care are as much a part of the public health nurse's service as giving care and treatment directly.

Four or five months' experience is obviously not enough for drawing conclusions as to whether care extended from hospital to home can and should reasonably be considered a part of the general public health nursing service of a health department. Nor is it long enough to determine the conditions under which this is possible, if feasible.

We as public health nurses are naturally as much if not more concerned with the social values of home care to the patients and their families as we are in relieving pressures in hospitals. Preparation of the family and patient for accepting home responsibility and care respectively, and seeing that conditions in the home are conducive, at least not inimical, to the patient's and family's welfare are of first importance in a home care program of any kind.

On the social planning and administrative side, questions that naturally arise are whether the official public health nursing service should give home nursing to patients still under the care of official hospitals and visiting nurse associations to other patients; or whether it is equally economical or in other ways desirable for the city to contract for this care with visiting nurse associations; or whether health departments and visiting nurse associations should combine their staffs to give all the public health nursing needed in the community, including home care of the sick.

NOW, A BRIEF review of diagnoses, age groupings of patients cared for in the brief period of our experience, and the kinds and amounts of service our public health nurses have so far given.

As previously stated, the program started officially in November 1948. Patients really began to be admitted to Health Department services in December when only two of the four health center districts of Queens were included. The maximum number of patients to be cared for, it was agreed, would be 100. After a few weeks' experience it became apparent that restriction to only part of the borough was impractical. After March 1, 1949, therefore, all of the borough was included.

Between the first admission to and including March 31, 1949, 107 transferred patients were admitted to care by Health Department nurses in two health center districts of the borough of Queens. Of the 17 patients so far discharged from home care, 7 died at home; 6 returned to the hospital (of whom 3 died); 3 moved out of the district served; and in one case, the family refused home care after a first visit had been made.

Age. The patients transferred range in age from 19 months to 83 years. That the majority of patients are in the older age group is evident from the tabulation which follows of the ages of the 90 patients who at this writing remain under care:

Under 10 years	3
10-29	4
30-39	7
40-59	19
60-79	48
80 and over	9

Diagnosis. Medical and surgical conditions and long and short term illnesses are included. As would be expected for the age groups represented, the conditions are predominantly those characteristic of late middle and old age. The 19-months-old baby had otitis media and a 10- and a 15-year-old had rheumatic fever.

By principal diagnoses, analysis of the service load of 90 patients showed:

Diseases of the heart	19
Cancer	15
Diabetes	6
Rheumatic fever	4
Circulatory conditions	7
Respiratory conditions	5
Other medical conditions	8
Fractures	16
Other surgical conditions	7
Neurological conditions	3

Visits and Services. The total number of visits of all kinds to the 107 patients admitted since care began was 914, or an average of 8.5 visits per patient. The duration of the visit averaged about an hour. Kinds of treatment given, besides general care were:

Intramuscular injections
Colostomy irrigations
Insulin administrations
Bladder irrigations
Enemas
Surgical dressings
Ear irrigations
Douches

Also diet therapy, crutch walking and urine analysis were included. Health guidance and instruction related to the whole family as well as specific teaching of family members to give care to the sick person transferred from the hospital are of course highly important aspects of this home care.

As our experience accumulates it will be important to find out how many of the families in which this care was given were already known to the Health Department nursing service and for what reasons. By the same token, it will be interesting to learn to what extent these families had previously been given service by the Visiting Nurse Association.

Another aspect which will be studied is that of cost of this kind of nursing care as part of a general official public health nursing service.

COMMISSION ON CHRONIC ILLNESS

Organization of a national Commission on Chronic Illness took place in Chicago May 19-20, culmination of a year's work by the American Hospital Association, American Medical Association, American Public Health Association, and the American Public Welfare Association, to carry out a major recommendation of the National Health Assembly, held in Washington, in May 1948. Leonard W. Mayo is chairman of the new commission.

Membership of the commission will consist of 30 persons representing broad fields of interest, experience, and knowledge. The commission will be assisted by 32 technical advisors selected on the basis of their experience and achievements in fields related to the care of the chronically ill. The technicians met in Chicago on May 19 to discuss the commission's aims and activities which fall into five areas (1) clinical problems (including prevention and research) (2) institutional care (including hospitals and nursing homes) (3) noninstitutional care (4) rehabilitation and convalescence, and (5) community problems. On the basis of the technical group reports, the commission will prepare a report on its future program. This is expected to follow tentative goals already drawn up by the four organizing groups. Briefly stated these are: to modify society's idea that chronic illness is hopeless and to substitute a dynamic program to prevent chronic illness, minimize its disabling effects, and restore its victims to a socially useful and productive place in the community; to coordinate separate programs for specific diseases with an effective general program designed to meet the needs of all chronically ill persons; to clarify relationships among professional persons and groups in this field; to stimulate state and local plans for prevention and control of chronic illness and for the care and rehabilitation of the chronically ill.

Three nurses—Ruth W. Hubbard, Ruth Freeman, and Marian Randall—are among technical experts working with the commission.

THE MEDICAL SIGNIFICANCE OF OUR AGING POPULATION

FREDERIC D. ZEMAN, M. D.

BEFORE a discussion of the effect of our aging population upon medical science and medical practice, definition of terms is necessary. In 1909 the late Dr. Ignatz Nascher of New York City coined the word "geriatrics" to denote a branch of medicine devoted to the diagnosis and treatment of disease in the aged. Although this word "geriatrics" is rapidly approaching a respectable middle age, it is only within the last few years that it has come into general use, and there are still many physicians who are unfamiliar with its meaning. It does not imply that the disorders occurring in older people should constitute a medical specialty, since these conditions are an essential part of internal medicine. It is to be looked upon rather as a convenient word, grouping together a variety of related concepts.

Another new term that we must all learn is "gerontology." This means literally the science of old age, or more broadly, the scientific study of the aging process in all living matter. Where geriatrics is limited to human beings, the student of gerontology also utilizes rats, mice, dogs, birds, elephants, or amoebae as they suit his purposes. In another sense geriatrics works at the bedside, gerontology in the research laboratory.

The increasing interest of physicians in geriatrics and gerontology is directly traceable to the change in character of medical practice. As a result of the larger number of older individuals in the general population more and more of the physician's patients are over 50 years of age. With improved living conditions there is today a hiatus of health in the life history of most people from the age of 10 years to the age of 50 years. With increasing awareness more attention will be paid by both patient and physician to tracking down in these apparently healthy years the earliest signs of the disorders that first appear in later life.

The Romans believed that old age was itself a disease *(senectus ipsa est morbus)*, and medical writers for many centuries thereafter recorded remedies for a great variety of senile complaints without having any understanding of the underlying causes. Only in the past hundred years with the development of modern medicine, which is based on the correlation of clinical and post-mortem observations, and is aided by methods of precise measurement, has it been possible to attempt the differentiation of the aging process, characteristic of all living matter, from the superimposed diseases occurring in the aged.

UNDER THE designation of aging process we group all these changes not attributable to any known disease process. It is recognized by alterations in the structure and the function of the cells, tissues and organs. Among these may be mentioned dehydration, decrease in tissue elasticity, impairment of muscular strength, and gradual diminution in vision, hearing, memory, and mental endurance. While these alterations may sound formidable, they come on so gradually that only rarely do they of themselves give rise

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to clinical manifestations. The one universal exception that comes to mind is the stiffening of the lens of the eye which necessitates the use of reading glasses at the age of 45 to 50 years. The aging process in ways not yet understood seems to make the individual more susceptible to diseases of various kinds. Among these are certain types of infections to which the older person apparently loses the power of resistance. Increasing scientific knowledge is continually forcing us to ascribe to disease or deficiency bodily alterations formerly attributed to the aging process.

Clinical studies have abundantly demonstrated what has always been known to the man in the street: that the older one becomes the greater is the liability to disease, and the greater is the number of diseases that may be found in any one person. This multiplicity of lesions in the old is most confusing to the physician since it often makes both diagnosis and treatment most difficult. Careful clinical judgment is required to decide which one of several diseases is responsible for the patient's discomfort, and to determine upon a course of treatment which will combat this specific disorder without affecting other parts of the body injuriously.

That many old people overcome their natural and acquired infirmities and carry on useful active lives, may be observed on every hand, and was especially evident during the war years. The chronological age of an individual may be most deceptive. Since some are old at 40 years, while others are relatively young at 70, we have long been aware of the importance of estimating the functional capacity of the aged. This may be defined as the ability of an old man or woman to engage in purposeful activity, and is only indirectly related to the pathological lesions that may be found on physical examination. Careful study of the capacities of older people will make it easier to assign them to suitable work.

I have long made it a habit to speak of "disease in the aged" rather than of the "diseases of old age," because, to use Worcester's words, "There are no diseases peculiar to old age, and very few from which it is exempt." The erroneous belief that old age and sickness are synonymous leads to serious mistakes on the part of both patients and physicians. The old man who accepts every pain and ache as the inevitable companion of his years fails to seek or to benefit by medical aid. The physician who says to his patient—"What do you expect me to do for you? Remember your eighty years!", not only ignores the possibility of help, but at the same time odds to the disillusionment and frustration of his patient.

Many medical errors in the care of the aged stem from sterotyped thinking. Every heart case is not due to arteriosclerosis of the coronary arteries. Occasionally the alert clinician will pick up a heart failure due to thyrotoxicosis, or a case with heart murmurs and fever due to subacute bacterial endocarditis. Both of these conditions may be curable in the old. All strokes are not due to cerebral hemorrhage or thrombosis. Subdural hematoma, due to an injury, may simulate apoplexy, but may be detected if a history of trauma is sought. This condition yields to surgery. The so-called "winter cough" of the elderly is often due to an open pulmonary tuberculosis. These examples might be multiplied indefinitely to indicate that the field of geriatrics offers great opportunities for an aggressive attack on disease, but demands specialized knowledge and skill from the practitioner, since the ordinary disease picture is often modified or even wanting. I have often summed up these observations for my students in the epigram, "Disease in the aged is characterized by multiplicity, chronicity, and duplicity."

SPECIAL CONSIDERATION must be given to the psychiatric problems of the aged. Their mental attitude was vividly described many years ago by the poet Horace. These lines should be familiar to many, since they contain the famous, "*Multa incommoda circumveniunt senem*", and "*Laudator temporis acti, se puero.*" I would be violating long established tradition were I to talk about old age without quoting this passage. In translation, we read:

> Grey hairs have many evils; without end
> The old man gathers what he dare not spend,
> While as for action, do what he will,

Hieroglyphic inscription which reads, "To be old is evil for people in every respect,"—from an ancient Egyptian Wisdom-book, "The Precepts of Ptah-hotep." The seventh figure from the left, a bent human figure leaning on a staff, is the hieroglyph for "old age" or "to grow old" and it is found in inscriptions as early as 2700 B.C.

'Tis all half-hearted, spiritless and chill;
Inert, irresolute, his neck he cranes
Into the future, grumbles and complains,
Extols his own young days with peevish praise,
But rates and censures these degenerate days.

For succeeding generations the portrait has lost none of its accuracy. In the last quarter century a steadily growing understanding of the mind in old age has led to extension of the mental hygiene movement to the later years of life. We have ceased to blame the old for their peculiarities. The effort has been made to explain why old men grumble and complain, why they seem to have lost interest in the world and why they lose confidence in themselves. While completely satisfying answers to all these questions are not available, enough insight has been gained to make possible programs for bringing more happiness, greater satisfaction, and less frustration into the lives of the old. Such aid is given for example in the Recreational Centers for the Aged of New York City Department of Welfare. Provision of economic security alone is not enough to achieve our ends, since the well-to-do must face reality as well as the indigent.

I cannot stress too strongly that the mental abnormalities seen in the aged are not necessarily the result of age. Many of the difficulties date back to personal maladjustments of long duration. The immature, the compulsive, the narcissistic, the psychopathic personalities often attain old age without the improvement of "mellowing" that long years are popularly supposed to bring. Of all the adjustments that life demands, the realization of old age and the adaptation to it is the stiffest test of mental stability. It is not surprising that those who have previously had difficulty in meeting reality will have even greater trouble at this trying period.

As regards the psychoses of this period, let me point out that here too, refined and painstaking diagnosis is required to separate the psychoses caused by parenchymatous vascular deterioration from the many conditions that may simulate them. Psychoses originating in youth may continue into old age, and if the earlier history is not known, may cause confusion. Dr. Manfred Guttmacher of Baltimore has given us a fascinating book, *America's Last King*, a psychiatric study of King George the Third, who, as we all learned at school, was insane. What we did not learn was that he suffered from manic depressive psychosis. The first attack was at the age of 26 years. The fifth, fatal attack occurred at the age of 84 years, and is in no way to be thought of as a disease of old age.

Cerebral disturbances in the old may be due to nutritional deficiencies, to drug intoxications, to brain tumors, as well as to overwhelming misfortune, the so-called "reactive depressions." Some of these depressed states in the old are successfully treated by shock therapy. Vitamin administration will clear up the deficiency states, and withholding of drugs will likewise have a curative effect. Psychoses after operations are not rare among the aged and are to be ascribed to complex causative factors. The important thing to remember is that the outlook is good for complete recovery under appropriate treatment and good nursing care. I hardly need warn you that in legal procedures relating to testamentary capacity all of these possible toxic or temporary causes must be ruled out. I do not want my optimism over the cases that can be helped to obscure the tragic picture presented by true senile dementia. The increase in the number of these cases has gone hand in hand with the percentage increase of aged in the general population and their care in state hospitals presents one of our gravest problems.

The vast strides of modern surgery due to improved pre-operative and post-operative

care, to newer anesthetics, to liberal use of parenteral fluids, plasma and whole blood transfusions, have brought inestimable benefit to aged patients. Today the medical man and surgeon have no hesitation in recommending surgical treatment in patients of advanced age in spite of obvious complications. By surgical treatment of hernia for example we can not only bring comfort to the patient but can also prevent the serious complications of strangulation and gangrene of the bowel. To the credit of orthopedic surgeons must go the improved technic of pinning fractures of the neck of the femur, once an accident entailing long suffering and high mortality in aged women. The results today are exceptionally good as regards both life and function.

It is clear that in spite of our ignorance of the fundamental causes of the aging process and many of its consequences, we are nevertheless in a position today to carry out the admonition of the Psalmist—"Forsake me not in my old age, cast me not off when my powers fail."

UNDER THE HARD conditions of life the barbarian had no choice but to dispatch the aged and the infirm or leave them to starve in the desert. Under easier conditions of existence the Old Testament attitude toward the elderly came into being, and has governed our thinking for more than 2000 years. Today we feel not only the respect for long years, and the necessity for their protection, but take the more positive position that old age may also be fruitful, and that the old may be healthier, happier and more secure in a life where may be found opportunities for self-fulfillment and self-expression. The realization that individual dignity must be preserved, and that waning powers must be utilized, constitutes the reasoned opinion of our generation, a tremendous advance over our fathers and grandfathers.

To accomplish these ends for more people must be the aim of our community leaders in all the professions and in all levels of society. Education is all important for the aged themselves, for their children, for their employers, their physicians, their nurses, their clergymen. We must combat the mistaken idea that old age is necessarily a period of illness, or that old people are characteristically and invariably feeble minded. We must formulate programs of prevention—prevention of infections, of accidents, of vascular degeneration, of malignant disease and mental disease, and apply the knowledge already at hand to more and more people. Above all, unstinted support must be given to broadly based research programs which will be the source of new knowledge and new skills for future application.

Social welfare planning must include provision for a broadened base for old age assistance benefits, for more hospitals for chronic disease, for better utilization of present institutions and particularly for better teamwork among the voluntary health agencies. We emphasize that the preparation for life's later years must begin while we are still young and apparently bursting with good health. Such preparation must be both on physical and mental levels.

These are all possible programs,—attainable in any intelligent community, and conforming strictly to the Golden Rule—for the benefits accrue to all of us. The costs are certainly not prohibitive in a nation where the tobacco bill alone runs into many millions.

In conclusion I want to tell you about our great poet, Walt Whitman. He suffered a stroke of apoplexy at the age of 56 years, but continued in spite of physical handicaps to write stirring poetry for many more years. Some of these poems written when he was 70 are to be found in his *Leaves of Grass* in the section entitled "Sands at Seventy." One illustrates well the creative capacity of older men and expresses great and inspiring thoughts.

> Not from successful love alone,
> Nor wealth, nor honor'd middle age,
> nor victories of politics or war;
> But as life wanes, and all the turbulent passions calm,
> As gorgeous, vapory, silent hues cover the evening sky,
> As softness, fulness, rest, suffuse the frame, like fresher, balmier air,
> As the days take on a mellower light, and the apple at last hangs really finish'd and indolent-ripe on the tree,
> Then for the teeming quietest, happiest days of all!
> The brooding and blissful halcyon days!

GENERALIZED PUBLIC HEALTH AND INDUSTRIAL NURSES WORK TOGETHER

MARGARET A. SCHWEM, R.N.

IN OUR present-day economy, industry is taking an increased responsibility for workers' health. And in providing a well organized medical department it contributes to the total health resources of the community. Among the key people of the medical departments of industry are the industrial nurses, who are in a position to work closely with other agencies and nurses functioning in the same locale.

Recently Mabelle Markee, nurse officer in the USPHS Industrial Hygiene Division, notes as one of the outstanding trends in industrial nursing, the changing emphasis of the program. The interest today in industrial nursing is not only in the prevention and treatment of occupational diseases and illnesses, but in the complete program of adult health correlated with the overall community health program.[1]

However, few generalized public health nurses have exploited to the full the possibilities of a cooperative working relationship with the industrial nurses in their community. Satisfactory interagency coordination is usually based on the friendly person-to-person contacts of the professional workers. The generalized public health nurses may be expected to make the first overtures of friendliness to the industrial nurses in their working area, because their schedules are more elastic and they have a means of transportation. The duties of the industrial nurses are of such a nature that it is necessary for her to remain in the plant unless special provision is made for her relief.

In the Syracuse District of New York State, an attempt has been made to introduce apprentice public health nurses early in their field experience to the concept that industry plays a vital role in maintaining high health standards in the community. They are introduced in a pre-observation conference to the scope and objectives of industrial medicine and the part played by the plant nurses. Each nurse then spends a day in a plant which is located in the area in which she works or which draws workers from her area, to observe the medical department in action. In a post-observation conference, each apprentice nurse shares her experience with other members of the group, and discusses any questions which may remain unanswered. These conferences are led by an industrial hygiene nursing consultant.

IN HER CONFERENCE with the public health nurse, the industrial nurse learns of the public health program planned and carried on in the area from which the plant draws its workers. She becomes acquainted with routine and special clinic services of the health department, as well as other community re-

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[1] Markee, Mabelle. Highlights in industrial nursing. *Industrial Nursing*, v. 33, December 1948, p. 16.

sources for convalescent care, child placement, and mental hygiene.

The industrial nurse may also find it valuable to spend some time in the field with the public health nurse for first-hand observation of the program of the health department in her area. Information regarding current illness trends in the community will alert her to suspect communicable diseases and refer sick employees to the plant physician for early diagnosis.

By making home visits with the public health nurse, both gain valuable mutual insight on personal, family, and community problems as related to the workers and their health. Housing problems or family illness may give a clue to the cause of accident repetition, nutritional deficiencies, or psychiatric needs.

There is another advantage to be gained from personal contact between public health and industrial nurses and a mutual understanding of each other's program. In making interagency referrals of patients, one nurse is often able to transfer the good will of the worker and family to the other nurse and agency.

Perhaps the plant nurse is referring a worker to the chest clinic for x-ray. She may reassure him regarding the new service he is to receive by telling him of the personnel and routine of the clinic. The public health nurse, on the other hand, may encourage a worker she is in contact within the community to return for a suggested check-up at the medical office, interpreting the value of this service to him. Her knowledge and understanding of the medical services available enable her to increase the worker's confidence in the plant medical service.

Public health nurses often find a valuable ally in the industrial nurse who is able to see and work with the father of the family whom a community nurse seldom finds at home. Perhaps she may encourage or arrange for him to have a needed examination or treatment, urge him to plan for orthopedic care for a crippled child, or refer him to the proper agency to meet special health or social needs. However, close working relationships are essential if both nurses are to work toward the same goals by similar means so that the family will not be confused by conflicting teaching and information.

Many industrial nurses have contributed to the maternal welfare of a community by encouraging employees to report pregnancy early without fear of immediate discharge. The mothers may then be urged to seek medical supervision by the family doctor or prenatal clinic. According to the recommendation of the physician made to the medical office, work may be continued, modified or discontinued depending on what is best for the mother. The alert plant nurse can usually find a way to give these workers a little extra supervision and guidance, and refer them to the public health nurse when indicated.

To enable the medical office to help the workers make best use of community resources, presupposes they have accurate and up-to-date information about all services offered. Public health people have often failed in this respect, and the public health nurse is the logical person in some organizations to make sure that announcements of all services, such as well baby conferences, mothers' classes, and immunization clinics, are sent to the industry's medical office.

Another manner in which the community health program may be enhanced by cooperation with industry is in planning for the rehabilitation of certain workers. The recommendations regarding the type of work suitable for discharged tuberculosis patients, for those under orthopedic or venereal disease treatment, usually flows through the medical department to the personnel office. The industrial nurse may be called upon to interpret these recommendations in terms of available jobs. In addition, she is able to observe these workers frequently to prevent relapse and poor adjustment to the new work situation.

THROUGH THE medical department, community health education programs may be extended into industry. The plant physician and nurse as well as representatives of management and labor should be included in the membership of community health councils. The health and safety committee of the plant may act as the subcommittee within the in-

dustrial organization to encourage worker planning and participation in plant and community health programs.

When chest x-raying and blood testing programs are taken into industry proper, they are officially approved by the medical department. However, in her routine contacts with patients, the nurse can encourage workers to take advantage of the service being offered. Bulletin boards and the company newspaper are frequently used to give added publicity to such surveys and the nurse within the plant is alert to use her influence to arouse favorable sentiment. In the same way the medical department may popularize and boost a health service not being offered within the plant, but in the community.

The public health nurse, who has access to health education aids from many sources, can supply the plant with materials that can be used in this manner, and suggestions for materials on general topics related to health.

It is the responsibility of each nurse employed in public health or industrial health services to look to her own situation to discover how best she can bring about sounder working relationships in her own community. No agency functions to full capacity which works alone.

Toward this end industrial and public health nurses might profit by joint educational meetings, and such meetings are now frequently being planned as a part of District Nurses Association programs. It does not seem illogical that industrial nurses be included among those who are eligible for postgraduate training assistance under health department funds. Sound programs are being developed in several universities so that industrial nurses now have access to good postgraduate training.

Some suggestions have been made for better cooperation between industrial and generalized public health nurses working in the same area. An awareness of each other in the community, the recognition of a common goal, and a mutual respect of the merit of each other's functions are prerequisites to a happy, effective working relationship.

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TEAMWORK IN HEALTH SERVICE

FRANZ GOLDMANN, M.D.

THE WORD "teamwork" is one of the most overworked words in the vocabulary of persons interested or actively engaged in the organization and administration of health services. Countless statements of the need for teamwork appear in scientific papers and popular articles, laws and administrative regulations, and proceedings of conferences dealing with health programs operated under the auspices of public or voluntary agencies.

Is the current emphasis on teamwork just another of the "crazes" vigorously promoted today and completely forgotten tomorrow or is it the manifestation of the belief in a sound idea likely to endure and grow? This question is not hard to answer. The sum total of knowledge has become so great and complex and the skills necessary to "do a good job" have grown so diverse that they cannot be mastered by a single individual. In the age of specialization systematic cooperation is imperative if we want to reap the full benefits that can be derived from scientific and technological progress. Teamwork is necessary for good and complete service to the individual and for effective practice by the members of the health professions, regardless of their participation in a health program. It is essential to both the establishment and the efficient and economical operation of any health program, no matter how it is financed.

According to Webster, teamwork may be defined as "work done by a number of associates, all subordinating personal prominence to the efficiency of the whole." Its prerequisites then are organization of systematic cooperation of various agencies as well as persons and willingness of each member of the team to give and take in the interest of a common objective.

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OBJECTIVES

The broad objectives to be attained through teamwork in health service may be summarized as follows:

1. To help the individual to keep healthy and fit, mentally as well as physically, and to lead a personally satisfying and socially useful life

2. To diagnose and treat as early, competently, and completely as possible all the abnormal health conditions of the individual and to bring to light and include in the treatment plan all the emotional and socio-economic factors bearing on the abnormal health condition

3. To help the members of the various health and related professions and the clinics and hospitals to render qualitatively and quantitatively adequate service to the individual in health and sickness, make necessary referrals promptly, respect each other's "sphere of interest," and appreciate each other's work

4. To help official and nonprofit voluntary agencies to plan properly for the establishment of needed facilities and service programs for the community

5. To help governmental and nongovernmental agencies administering health programs to discharge their functions effectively and economically with due consideration to quality, comprehensiveness, continuity, and consistency of service and

6. To offer scope for citizen participation

in the initiation and administration of community health programs and assure their democratic control.

PROCEDURES

To state objectives is one thing, to develop and carry out appropriate procedures quite another. Not infrequently the very people who are indefatigable in preaching teamwork fail to pay enough attention to the dominant importance of administrative methods suitable for proper execution of the task. The following outline of the principles of action and technics adopted by various types of organizations will serve to show how the solution of the problem may be approached under given circumstances.

Referral of patients. "A well organized referral system is essential to the adequate care of the patient, the proper and economical utilization of hospitals and clinics (out-patient departments, dispensaries, et cetera), and the efficient operation of health agencies outside the hospitals." This is the opening sentence of a program of cooperation in referring patients that has recently been concluded between seven hospitals, one clinic, two official agencies administering public health nursing services, and one voluntary visiting nurse organization in Boston. The written agreement defines the objectives of the referral plan, describes procedures recommended for adoption by hospitals and agencies outside the hospitals, and provides for a *single* standardized "referral form" to be used by *all* participating agencies. The standard "inter-agency referral form" contains space for personal data, reports by the attending physician, nurse, physiotherapist, dietitian, and medical social worker on the hospital staff, and the report by the community nursing agency. Its proper completion is facilitated by a written guide and promoted by explanatory talks before the staff members of the agencies concerned. One copy of the form becomes the permanent record of the hospital, the second copy becomes the permanent record of the community agency, and the third one may or may not be destroyed depending upon the policy of the agency or the hospital. The content of the form adopted in Boston is quite similar to the "Greater New York Inter-Agency Referral Form."

The significance of the "Boston Inter-Agency Referral Plan" lies in the fact that several agencies of different type have taken joint action to avoid the dangers inherent in separateness, if not "splendid isolation," have endorsed a set of general principles and specific procedures designed to assure the closest possible cooperation, and have agreed on the substitution of one standard form for the numerous forms with different contents used previously.

Staff conferences at group-practice clinics. Regular medical staff meetings and systematic reviews of the clinical experience in various departments on the basis of the patients' medical records are considered mandatory for any hospital meeting minimum standards. If well organized and properly conducted they serve to stimulate cooperation of the hospital staff for the welfare of the sick. Outside of hospitals such procedures are very difficult to institute and carry out, unless there is a setting conducive to this purpose. Due to their very method of organization group-practice plans, using clinics as headquarters, afford unique opportunities for teamwork between general practitioners and specialists, between the various specialists, between physicians, dentists, nurses, technicians, health educators, nutritionists, and social workers, and between professional and administrative personnel. An interesting illustration of the use of administrative methods for the promotion of teamwork is afforded by the Labor Health Institute, St. Louis, Missouri, a group-practice organization offering comprehensive service at the home, clinic, and hospital in return for regular prepayments. Every week medical staff meetings are held for the purpose of attaining the highest quality of service by utilization of all diagnostic and therapeutic methods required, with review of all "hospital cases," and appraisal of total service rendered. There are weekly meetings of a "professional executive committee" responsible for advising the medical director in all professional matters and of an "administrative com-

mittee" charged with coordination of the activities of the eleven departments, including the nursing department, of the Institute.

The administrative methods employed by the Labor Health Institute in its effort to weld the staff members into a group are noteworthy in four respects. Promotion of high quality of service receives primary consideration. The scope of the service is broad, including preventive services as well as all basic types of treatment. The patients are followed up through the stages of acute illness and convalescence, regardless of whether they are treated in the hospital, clinic, or home. The members of the professional staff have not only full responsibility for all professional matters but also opportunity to take part in the overall administration of the program.

Post-clinic conferences. In many states "post-clinic conferences" are held following the regularly scheduled field clinics for children accepted for service under the crippled children's programs. They are designed to facilitate the exchange of opinions on the health conditions and needs of the children examined, the preparation of the most appropriate treatment plan for new patients, the review of cases seen before and the decision on children apparently ready for discharge. In Massachusetts the typical post-clinic conference proceeds as follows. New patients are discussed first, with the district health officer or the clinic secretary reading the diagnosis and treatment recommendations of the orthopedist or other specialist and the social worker, the physiotherapist, the supervising nurse, and the nutritionist each presenting summaries of their own findings. On the basis of this joint analysis the total treatment plan for the new patients is determined and the local public health nurse is made responsible for follow up. Next, the old patients and those who failed to appear are discussed, the records of patients under consideration for discharge are reviewed preparatory to final decision by the orthopedist at the next clinic session, and difficulties encountered are brought up and eliminated, if possible. The notes on the post-clinic conferences are included in the records of the various children.

The value of such conferences cannot be overestimated. All the professional persons concerned are helped to see "the whole" rather than some parts, to prepare jointly the total treatment plan for the patients, and to work together smoothly. The physically handicapped child whose adequate care poses so many intricate problems profits greatly from such teamwork, as experience has shown.

Teamwork in home care. The feasibility and effectiveness of home care depend on (1) environmental conditions conducive to the purpose (2) coordination of the services of physicians, professional nurses, practical nurses, housekeeping aides, and social workers, if not also nutritionists and physiotherapists and (3) proper selection, intelligent assignment, and close supervision of the auxiliary personnel.

In a number of large cities, such as Boston, Massachusetts; Detroit, Michigan; New Haven, Connecticut; New York, New York; and Richmond, Virginia, more or less comprehensive systems of cooperation to stimulate teamwork have been worked out. The methods employed for this purpose include some or all of the following: exchange of opinions by telephone in regard to the observations, findings, and recommendations of the various professional persons and auxiliary personnel involved; exchange of written reports on diagnosis, treatment plan, and progress; joint visits of members of the team to the home of the patient, the office of the attending physician, or the office of one of the agencies for the purpose of mutual consultation; use of one family record instead of many separate patient records; and regular staff conferences for all public health nurses, social workers, and nutritionists in a given area in order to foster joint evaluation of their work.

Such arrangements are noteworthy in two respects. They place the emphasis on completeness of service to the home-bound patient by taking into consideration the emotional and socio-economic factors as well as the physical condition and integrating the activities of several persons with different background, experience, and skill; and they provide for controls to prevent inadequate service and for

self-evaluation of the work of the agencies concerned.

OBSTACLES

As could be expected, the progress from lip-service to sound action has not always been easy. Some of the obstacles can be traced back to deficiencies in organization and can be removed by adoption of better administrative methods. In this category belong the following difficulties.

Successful physicians, general practitioners as well as specialists, have little time to spare for conferences. They want to be sure that such time as they are ready to spend on meetings will not be wasted by listening to people who like to hear themselves or liberally digress from the subject matter. At the risk of laboring the obvious it must be stated that the agenda of meetings should be carefully prepared, the speakers be concise, and the conferences be brief and firmly led.

Occasionally, especially in the case of patients with complicated illness or serious impairment, so many experts are needed for consultation that all of them could hardly be called together for a joint conference. Under such circumstances reading of the recommendations of the absent specialists appears to be the only way out of the dilemma. Often attendance at conferences may be poor because the physicians cannot help but give priority to requests from their private patients. For reasons of fairness and prudence those physicians and other professional persons in private practice whose opinions are sought should always be paid an equitable compensation for the time spent on administrative meetings as well as on conferences dealing with service to individual patients.

In the field of nursing service four obstacles seem to retard progress toward teamwork. There is first of all the difficulty of reaching an agreement on the functions to be performed by the members of the future hospital nursing team, including professional and practical nurses, and by the members of the future home nursing team composed of professional and practical nurses as well as housekeeping aides. Secondly there is the intricate problem of devising methods of direction and supervision which hold promise of stimulating recognition and acceptance of interdependence without stifling independence. Thirdly, it is anything but easy to achieve whole-hearted cooperation between physicians in private practice and public health nurses and between physicians and nurses on hospital staffs. Last but not least it requires the wisdom of a Solomon to assure the best possible relationship between hospital nurses and medical social workers on the hospital staff, between public health nurses and social workers on the staffs of community agencies, and between public health nurses and health educators. In the opinion of many experts, this problem can be settled by division of responsibilities according to the functions each group is best equipped to perform. However, division of responsibilities will be of little avail unless it is accompanied by unification of effort.

The best intentions to develop teamwork might be defeated or the most beautiful scheme agreed upon might remain a paper proposition because of the undeniable fact that there is a good deal of human nature in man. Fear appears to be the primary motive prompting outright opposition to the principle of teamwork or slow response to the obligations inherent in any plan of cooperation. In the opinion of some people, medicine, dentistry, nursing, and the related professions might lose the best they can offer if an "impersonal group" rather than a single conscientious well trained professional person assumes responsibility for the care of the patient. This argument obviously mistakes the means for the end and overlooks the fact that well organized teamwork offers each team member more opportunity for better work in his own field and under his own responsibility. Some people are afraid they might be forced to make poor compromises or sacrifice their personal opinion to the conviction of the group. Some others are suspicious they might be treated as "inferior" members rather than as full-fledged partners of the team or somebody might "steal" their patients. Such fears are not easy to dispel but they can be alleviated and gradually eliminated by setting a good example in a community offering a promising testing ground.

PSYCHIATRIC SOCIAL WORKER AS CONSULTANT

ALICE WARINNER

WITH THE passage of the Mental Health Act by the 79th Congress delegating the responsibility for developing mental health programs to state and local health departments, an increased awareness of the need for staff education in mental health for health workers has developed. Because public health nurses are the channel through which the services of the health department directly reach the patient, they are the ones who most actively recognize the need for additional preparation. The nurses, consciously or otherwise, constantly apply the principles of mental hygiene in helping their patients to achieve the habits of healthful living. These principles used to be known as "common sense."

However, at even this late date many nurses in their basic training are not taught how to apply consciously the available knowledge regarding human behavior nor the technics which can be used to help people fulfill their potentialities. Even many well prepared nurses do not always see themselves as capable of handling the simplest emotional problems and may think that matters relating to feelings and attitudes are best left alone. With the current emphasis upon mental health as a public health responsibility and with the realization that epidemiological approach to mental health must be developed in a way not unlike that which is used in communicable disease, the public health nurses' obligation to refine their skills in mental hygiene is self-evident. By turning for leadership to other professions whose training is more specialized in this area, they can both broaden their point of view and sharpen their technical skills. In settings where such resources are available, public health nurses have benefited by the use of a psychiatric social worker as consultant, not only in relation to specific case situations but in staff education, program planning, personnel problems, and community relationships.

For over a year the nursing division of the Topeka City-Shawnee County Health Department has used as consultant a psychiatric social worker who was lent by the State Division of Mental Hygiene to the Health Department. This paper is a preliminary report regarding that working relationship.

Both public health nurses and psychiatric social workers, in practice, deal with persons whose adjustment to the environment is temporarily or permanently distorted to some extent because of illness, or whose faulty environment has resulted in disturbances in health, or whose faulty attitude makes it difficult for them to channel normal impulses. Public health nurses bring for consultation problems selected during the supervisory process which involve patients' environmental and personal adjustments. This consultation

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is a collaborative activity in which the nurse, her supervisor, and the consultant apply their skills in the common area of the distress of the patient. Cases are brought to the consultant when it is felt that her special skills are needed to give the nurses additional insight into the problems and the technics of handling them. It is the responsibility of the staff nurse to present the problem as she sees it.

The method of consultation is a discussion by the nurse, the supervisor, and the consultant of the patient's history as revealed in the clinic record and the nurse's family folder. In the county area much public health nursing is done on the basis of school referral and the public health nurses are the school's channel to other community resources. These rural nurses have occasionally brought the patient's teacher into the conference both to clarify the problem and to help the teacher understand the patient.

In this connection, it should be noted that the consultation service itself was initiated by the nursing division because of the staff nurses' own awareness of need. The nurses' original request for consultation was in two general areas: further understanding of personality structure and help in the use of available community resources. More specifically, the nurses were aware of patients who were so sick that they could not use help well. The nurses felt a desire to be guided in the use of their own services with such individuals as well as in making other appropriate plans. They found resistance on the part of patients to use available medical and social resources and needed to develop more skill in dealing with it. While knowing which social agency could best serve the patient the nurses were sometimes at a loss to understand how best to present the patient's problem to the agency and the agency's services to the patient.

More recently the purposes and objectives for the staff nurses of the mental hygiene aspects of the nursing program, which are largely implemented by the use of the consultant, have been formulated:

The purposes are:

1. To gain increased insight into human behavior
2. To assist in the recognition and evaluation of emotional problems so that some plan may be made to meet the needs of the family
3. To give the individual nurse security in her relationship with the family and to help her evaluate her own attitudes and feelings in relation to the individual patient
4. To strengthen the nurses' awareness of available community resources and of patient's needs for which there is no resource.

The objectives are:

1. To prepare the nurses to give optimal service to the family and the individuals within it
2. To prepare the nurses to assume a role of leadership in the community toward the fulfillment of unmet needs in the total program of public health.

LET US EXAMINE the role of the public health nurses and the setting in which they practice. Our public health nurses function in the field, the public health clinics, and the general clinics. Although approximately 20 percent of the nursing service is bedside care, emphasis in the field is based upon health education of the patient and the social aspects of nursing. One part of the nurses' function is caring for the sick patient. They also have equally important responsibilities in education and prevention related to the health of the individual and the health of the community. The focus is on the family unit as well as the individual patient, on health rather than pathology. The county and city are districted and the nurses give all service within their respective districts.

There are 27 clinics of two distinct types in the Health Department—the public health clinics and the medical care clinics which are a joint activity of the County Board of Social Welfare, the Medical Society, and the Health Department for the care of the medically indigent. It has been found that the public health nurse has a teaching function in the medical care as well as in the public health clinics. Therefore, the nurses and the social worker are related in practice to the total clinic services. Nurses rotate through the clinics and because of their intimate knowledge of the field there is closer coordination between the nurses serving in the field and in the clinics.

Particular mention should be made of the neuro-psychiatric clinic because it is due to this clinic that the psychiatric social worker

is on the health department staff and the presence of this clinic has undoubtedly stimulated the nurses' awareness of emotional problems. There are two sessions of this clinic each week. It is staffed by psychiatrists from the out-patient and children's divisions of the Menninger Foundation. Because it is a part of the medical care plan, its services are available only to those persons who are already receiving public assistance or who are determined to be eligible by the County Board of Social Welfare because of inability to pay fees for private psychiatric care. About 34 patients are seen in this clinic each month. The major portion of the psychiatric social worker's time is spent in direct service to these patients, although, as stated above, she also gives clinical services to patients and physicians in the other clinics. The nurses refer a significant number of patients to the neuro-psychiatric clinic, both because of their contacts in the field and in the other clinics. In relation to patients known to them, the nurses function as a part of the clinical psychiatric team and participate in psychiatric staff conferences.

When the program started, the majority of the cases brought to the consultant were patients who were either already known to the neuro-psychiatric clinic or who were in the process of referral to this clinic. For some time there had been no social worker and the nurses took a great deal of responsibility for interpreting clinic psychiatric services to the patient. Early in the learning process it was easier for the nurses to discuss neuro-psychiatric patients because the need for joint planning with the social worker in relation to these patients was more obvious to them. The nurses identified the social worker with the neuro-psychiatric clinic and only as they developed insight through consultation regarding patients known to the clinic could they make a broader application of their knowledge. At present, in their referrals to the clinic, the nurses focus the problem with the patient sufficiently so that he will accept referral. They go into the family's financial status in order not to encourage those persons to apply who obviously will not be eligible for psychiatric care. They then prepare a summary for the psychiatrist based upon their knowledge of the patient and the psychiatric social worker takes a more comprehensive social history. When the case is discussed in staff conference after the diagnostic work-up is completed, the public health nurses contribute to the case discussion and receive suggestions from the rest of the staff, particularly in regard to the method of handling the patient in relation to their own function with the family. Many questions regarding psychiatric care, particularly problems of resistance, come to the nurses early in the course of treatment and the nurses then plan with the social worker ways to meet the patient's problem. When the nurses have the closer relationship to the patient they, instead of the social worker, may follow up on failed clinic appointments, again after a conference in which the patient's total situation is discussed.

However, as indicated above, this is but one area of use of the psychiatric social worker as consultant by the public health nurses. Many instances concerning the inability or reluctance of patients to follow medical recommendations are brought to the consultant. For example, in certain chronic diseases, patients may become overly hostile or self-protective to the point that they refuse treatment. There are instances of young women who are promiscuous and whose self-destructive tendencies are evidenced in repeated venereal infections. Many such patients require a sort of protective custody which is seldom available. It is difficult for anyone with a genuine interest in the individual and a concern for the public health to accept the fact that these patients may be unable to change. We find a tendency even in some well prepared public health nurses, perhaps as a result of their hospital training and many of their functions in the bedside nursing program, to *give-to* or *care for* the patient rather than to *teach* or *lead* him to cope with his own problems. In such instances nurses are assisted to recognize the patient's inability to use the services offered. If there is no community facility available to care for him, the nurses can and do inform the com-

munity of this lack through proper channels within the Health Department and the community. In this community, the function of the public health nurse as an interpreter of unmet needs is now beginning to be accepted. We believe that this acceptance has been facilitated by the activities of the social worker.

The public health nurses often must help a patient carry out medical recommendations which may necessitate considerable change in his manner of living. Sometimes the physician fails to take social factors into consideration. The nurses then must interpret to both patient and to physician. Some nurses find it difficult to point out to the physician his failure to recognize the patient's total situation in setting up a medical plan. The social worker as a consultant can reinforce the teaching of the nurses' supervisors, helping the nurses to an increased awareness of their professional role in their relationship with the physician. Because in much of their training and practice nurses function under orders from a physician, it is not only difficult for them to question his decision in terms of the patient's total life situation but some nurses may at times follow his lead blindly without realizing their own professional responsibility to the patient as a person. In this region such an attitude is fostered by the viewpoint of some physicians regarding the role of all nurses. The psychiatric social worker is accustomed to considering the social and emotional aspects of illness. Hence, she can point out to the nurse that the patient may be expressing resistance to following a medical plan because that plan is not feasible for him under present circumstances. Then the nurse and the social worker together can work out ways by which medical recommendations and the social situation can be reconciled.

On the other hand, because of their traditional training, some nurses tend to take an authoritative approach with the patient, expecting him to follow medical recommendations because they are indicated in terms of his pathology. When the patient fails to respond and becomes dependent upon the nurse or hostile towards her, she may be at a loss to know what to do next because she fails to understand what the patient is feeling. Nurses have limited training in interviewing technics and insufficient awareness of the existence of an emotional relationship between themselves and the patient and its effect upon the patient's response.

Such implementation of medical recommendations often also involves the patient's existing relationship to a social agency or necessitates initiating referral to such an agency. Establishing cooperative working relationships on a professional basis for the benefit of an individual patient with social agencies has been a real problem to the nurses and one which is repeatedly brought to the consultant.

IN CERTAIN AREAS both nurses and social workers complain that the other encroaches upon her field. Since both work with families, a certain amount of overlapping will occur and certainly need not necessarily be detrimental to the family. Social workers in this community sometimes fail to recognize the social implications inherent in all public health and most obvious in relation to the nurses whose professional practice is directly concerned with the family. Nurses sometimes feel insecure in relation to social workers in other agencies because the social workers do not always give the nurses the full professional recognition that they give to other social workers. Moreover, the nurses are not hampered by limitations of intake or eligibility in the way in which the social workers may be and some social workers may unconsciously resent the nurses' freedom to serve. Some nurses become impatient of the time which is often required before a social worker can put a plan into effect because of the nurses' tendency to give to the patient without full realization of what acceptance may mean to him, and because of the nurses' lack of realization of the way in which agency policies may control the social worker's service.

The consultant is sufficiently removed from direct service to the family to be able to help in the coordination between the agency social worker and the public health nurse. It

is the responsibility of the consultant to help the nurses become aware of the part their feeling toward social agencies plays in developing the relationship with the agency. The consultant can help the nurses control their hostility towards agency mechanics so that it hampers neither the social worker's nor the public health nurse's relationship to the patient. This feeling can be directed into constructive action toward improving interagency relationships. The consultant must help the nurses gain professional security through strengthening their awareness of the validity of their services to both the patient and the community.

The nurses whose districts lie outside of the city limits are closely associated in practice with the rural school teachers and it is part of the nurses' job to interpret community resources to the teachers. Many cases concerning poor school adjustment are brought to the consultant. Sometimes such children are referred to neuro-psychiatric clinic, in other instances the parents may resist referral, or they may not meet the eligibility requirements of this clinic and no other suitable community resource is available for them. Then the nurse, the teacher, and the consultant sit down together to discuss ways of helping this child and his family. Usually it is decided that the nurse shall work with the family, while specific suggestions are given to the teacher regarding handling the child in the classroom situation. Every possible effort is made to refer the patient to a suitable social agency or medical resource.

NOT SO DIRECTLY related to the care of the individual patient is the use made of the consultant by the director and educational director of the nursing division in regard to the total staff education, program planning, personnel problems, and community relationships. The psychiatric social worker has, of course, no administrative duties or responsibilities within the nursing division and the use that is made of her as a consultant is on a purely voluntary basis. The first step in consultation was in relation to the professional practice of the staff nurses, as described above. When it became time in August 1948, to plan the in-service training program for the rest of the year, it was the feeling of the staff that this program should emphasize the way in which personality and emotional factors influence the nurses' daily practice. The purposes and objectives of the mental hygiene program were felt to be carried out in part through the in-service training program and the consultant services. Therefore, it was recognized that the consultant could help both in setting up the program and integrating it into the daily practice of the nurses.

The in-service training program is related to the total staff and reaches both the nurses who need to develop an awareness of the interrelationship of the emotional and social needs of the patient with his total well being and nurses who already understand their role in the promotion of mental health. Of course, there is a wide variation among nurses in the frequency of requesting consultation. It is to be expected that in a staff of 20 field nurses and 2 field supervisors there will be those who reject the consultant services of a social worker and others who, possibly because of their own problems, are reluctant to accept any responsibility for helping patients with their feelings and attitudes on a planned basis. Thus the consultant service and the in-service training programs supplement and implement each other.

The in-service training program consists of a bi-weekly seminar conducted by two psychiatrists from Winter Veterans Administration Hospital, Topeka, Kansas. At the present time selected case material illustrative of the emotional aspects of pregnancy is being discussed. This area of discussion has been defined by the staff in order to implement the program, requested by the County Medical Society, of teaching classes for expectant parents. Additionally, the out-patient conferences of the children's division of the Menninger Foundation are being used as in-service training for the supervisory staff. These conferences are followed up by monthly discussions with the consultant so that together ways may be worked out of applying what the supervisors have learned to the supervisory process.

The Health Department is a field training

center for students in public health nursing from several universities. Students are assigned for a three-month period of supervised field experience in the nursing division. Nurses from other local health departments may also be assigned to the nursing division as trainees by the State Board of Health. These students are supervised by staff advisors under the leadership of the educational director who may consult with the psychiatric social worker regarding students' progress. Jointly we have tried to help students translate their knowledge from previous work or educational experience into public health nursing practice, and to help them apply mental hygiene technics.

The director of the nursing division has made free use of the psychiatric social worker's technical knowledge in order to gain insight into the personality structure of staff members whose personal adjustments affect their professional performance. Efforts have been made to modify the working situation so that the individual nurse can function at her optimal level. Individual supervisors and staff nurses have asked the consultant for help in understanding each other so that they might work together better. Staff have come to the consultant for help with personal problems. This is not to imply that the nursing division is rife with such problems. As a matter of fact they probably have less than other professional staffs of their size because of the democratic method of administration of the division. Rather, the staff has begun to understand that their own emotional conflicts do affect their professional practice and, what is more important, they want to do something about it. These problems, while affecting job performance, do so only in the same way that they affect the nurses' other inter-personal relationships. That they are discussed with the consultant need not mean that the relationship between the nurse and her supervisor is poor. Nor need such use of the consultant weaken the nurse-supervisor relationship any more than help in regard to case situations weakens the nurse-patient relationship. The nurses come to the consultant because they feel that her professional skills enable her to help them with objectivity and she is able to assist them to use resources for psychotherapy where indicated.

The director of the nursing division has also consulted the psychiatric social worker regarding her role on the boards and committees of several community agencies. She has been helped to take action toward augmenting community facilities for mental hygiene. Furthermore, the director has also used the psychiatric social worker in coordinating the Health Department with existing health and welfare agencies and improving the staff's working relationships with these agencies.

We are feeling our way in this program, but I think not one of us involved questions its value. We expect changes in emphasis with growth in the consultant in relation to public health practice and with growth in the nurses in the application of knowledge gained from the consultant. However, we now think that this is a plan which might have application to other like settings.

LOAN AND GIFT CLOSETS

MRS. CHARLOTTE PAYNE

"AN ACCUMULATION of articles designed to facilitate the care and increase the comfort of the cancer patient in his home"—that is the somewhat formidable description of one of the newest and most popular parts of the service program of the American Cancer Society. The articles in the Acs loan and gift closets range from permanent items, used again and again, as Gatch beds and wheel chairs and rubber sheets, to expendable materials,—bandages, swabs, bibs, magazines, slippers, and the like.

In the upstate Michigan Division 25 counties maintain closets to bring a measure of hospital comfort to the cancer patient in the home. Among the most valuable articles are the neat bed jackets made by volunteers from men's old shirts and the rubber rings that help make a bed endurable.

Josephine Brown, director of nurses of the Calhoun County Health Department in Michigan, wrote recently to the local cancer committee, "from my own knowledge of a loan cupboard and comments I have heard the nurses make, I feel it would be very difficult to do without one. It is of real help to patients, inasmuch as most families do not equip their homes with such articles as you have for loan. Then, too, with illness there is considerable expense which prohibits families from purchasing articles that make care easier to give and add so much to the comfort of patients."

In this particular county the loan closet includes food mills, hand juicers, food grinders, press squeezers, and electric juicers. Their value is indicated by an experience with a recent patient who had carcinoma of the esophagus and whose wife was unable to prepare food that satisfied his yearning for meat. The Acs sent a dietitian into the home to discuss the problem. A few days later the wife called the cancer committee and reported, "Your loaning us the food chopper and showing me how to fix Bill food that he can and will eat has made us both feel we can go on living and fighting. We had just about given up."

Mrs. Anne Moore, consultant nurse and director of the Acs Information Service in Nassau County, New York, feels that the chief value of the loan and gift closet is in mental hygiene. Morale of both patient and family is strengthened by the knowledge that there is an agency which will help them with dressings or beds or anything else needed. The closet's supplies often mean that a patient may be kept at home instead of being sent to a crowded institution. In counties like Nassau with rapidly increasing population, hospital beds lag far behind the need so the possibility of home care is a boon to both individual and community. Mrs. Moore says their closet is used by the 45 public health nurses of the county. While the number of patients served is not large, items from the closet are always in use and in demand.

In Brooklyn, Mrs. Mary Mangan, the nursing consultant of the cancer committee, says that in each instance a member of the family visits the committee office before the patient returns to his home. The type of dressings and the equipment that will be needed are discussed and all arrangements are completed so that transition from hospital to home may be an easy one. This committee has 8 hos-

Mrs. Payne is lay service director of the American Cancer Society, New York, N. Y.

The availability of the closet's supplies on loan often means that a patient may remain at home instead of being sent to a crowded institution.

pital beds and 5 wheel chairs that are in constant use. There is close cooperation with medical social workers, with the Department of Health, and the Visiting Nurse Association.

In Detroit the Visiting Nurse Association represents the Cancer Society in handling certain cases. In one recent instance, a patient with carcinoma of the breast was furnished a hospital bed and given an afghan, adhesive tape, gauze, rubbing alcohol, and bed jackets. In addition a volunteer drove the patient to the hospital for treatment every week, since the husband was threatened with loss of his job if he took the time off to drive his wife himself.

The loan and gift closet service seems to have originated in Atlanta where Acs volunteers made a practice of supplying indigent cancer patients with "comfort kits" when they were about to enter a hospital. The Washington Division opened the first closet in 1938, Vermont and New Jersey started theirs in 1940. Gradually the idea spread and was systematized with the issuance in 1948 of an Acs leaflet, "Cancer Loan and Gift Closets." Today about half of the Society's Divisions offer this kind of service to patients. Closets are also maintained under Society supervision by 38 branches of the United Order of True Sisters and by other philanthropic groups.

The Acs points out that these closets help relieve the physical, psychological, and economic burdens of terminal cancer. "The physical needs of the patient may make certain equipment essential, such as bedpans, basins, irrigators, thermometers, ice caps, drinking tubes and mattress pads. Beyond the necessities, other sickroom supplies may make life for the patient more tolerable. Back rests, lamps, wheel chairs, commodes, air fresheners, and dark window shades can convert weary existence into a measure of interested living . . . he may be able to do no more than to listen to the radio or to a reader, or he may enjoy reading books and recent magazines. Active participation in a hobby or craft, within physical limitations is highly desirable. . . ."

Loan and gift closets are a part of a broad program of service by volunteers in the American Cancer Society. The number of volunteers ranges in the hundreds of thousands; their activities vary according to the needs and the plans of each locality. Usually given top priority is the preparation of surgical dressings which are so important for the com-

fort of bed-ridden cancer cases. Last year some 3,500,000 dressings were made by volunteers. They also make bedpads, slippers, and many other articles.

Since treatment for cancer is often spread over many months, it may be difficult for the patient to make repeated trips to the doctor, clinic, or hospital. To meet this critical need many state divisions have organized transportation units. Another type of service that brings rich rewards to patient and volunteer is the home visitor program. This may include doing small services for the patient himself or be limited to such homely tasks as baby tending, cooking, mending, or reading aloud. Not the least important of volunteer projects is helping clinics and hospitals to handle the great load of clerical work.

The Society is well aware of the considerable dangers of using unsupervised and untrained volunteers. It is a para-medical organization, half of whose directors are physicians. In every division the program operates with the approval of state and county medical societies. No decision that enters the field of medicine is made without careful checking and clearance with professional leaders.

The record of volunteers during the war was revolutionary in its impact on health agencies. Much that had to be put off in the past because budget limitations made it impossible to hire professionals can now be accomplished by supervised volunteers. Special training courses introduce such workers to the problems they may meet. Supervision by physicians, nurses, and social workers guide them in their contacts with patients. Finally, there is no better way for the individual to familiarize himself with cancer and with the terrible challenge it presents to all of us than through this volunteer service.

This article has called the attention of public health nurses to loan and gift closets. A telephone message to the nearest ACS office will give you information about how you can use them in your work.

NURSING SCHOLARSHIP PROGRAM TERMINATED

As part of its educational program the National Foundation for Infantile Paralysis has during the past nine years granted a total of $218,925 to the National Organization for Public Health Nursing and the National League of Nursing Education to provide scholarships to qualified nurses for advanced preparation in orthopedic nursing. Limited numbers of scholarship applications from qualified nurses in some years has meant that not all of the scholarships made available by this grant were used. In June 1949, this scholarship program was terminated and it seems in order to review what has been accomplished.

The number of scholarships awarded to nurses totals 116. Of this number 96 nurses have completed the university study financed by scholarship and are serving in 24 different states, the District of Columbia, Hawaii, and Japan. Fourteen are in school at present and a few awards are still to be made to applicants who are now being considered by the scholarship committee. These scholarship awards were made in order to help nurses prepare for consultant, teaching, or supervisory positions, and it is of interest to consider the type of service now being given by former scholarship students. This is as follows:

	NOPHN	NLNE
Consultants with national nursing agencies	4	2
Instructors in university programs (6 part-time)	7	5
Consultants for official services for crippled children	13	1
Supervisors or instructors on special orthopedic programs with voluntary public health agencies	17	
Clinical instructors in orthopedic nursing		15
Clinical instructor in surgical nursing		1
Nursing arts instructors		2
Instructors in the orthopedic outpatient department		2
Supervisor of pediatric nursing		1

General staff nurse		1
Directors of nursing:		
In a university school of nursing		1
In a special orthopedic hospital		1
Participation in special program for children with cerebral palsy	3	
In school on scholarship	3	11
In school for further work following completion of study financed by NFIP scholarship	4	2
Interns (nurses having special supervised experience with selected public health agencies following completion of university programs)	3	
Did not complete studies for which scholarship award was made	2	4
Retired from nursing	5	6

From this it can be seen that the scholarship program so generously financed by the Foundation has far reaching and will have long lasting effects. The instruction of students by former scholarship students in schools of nursing, staff education programs in public health agencies, and teaching programs for graduate nurses in universities have helped countless nurses give better care to orthopedic patients.

While the record is encouraging, it by no means indicates that the needs in this field have been fully met. With increasing interest in orthopedic nursing on the part of graduate nurses, segregation of orthopedic patients in general hospitals, and plans for teaching programs in special orthopedic hospitals, there is a growing demand for well prepared orthopedic nurses as instructors and supervisors. Public health agencies as well as universities and hospitals are in need of nurses with special preparation to carry on present programs for the care of the orthopedic patient in his home, to assist in early case finding and prevention of deformities, or to function in new programs which are being started to meet needs in this field.

When the National Foundation for Infantile Paralysis orthopedic nursing scholarship program was first started there were few sources of financial aid for nurses who wished to specialize in this field. Today many states as a part of their overall program of providing adequate care for the orthopedically handicapped make available scholarships for nurses who will return to the state to serve either on the state crippled children's service or in hospitals caring for orthopedic patients.

A request for information regarding scholarships available and the required qualifications for applicants was recently sent to the crippled children's services of the 48 states and three territories. The 36 replies received to date gave the following information:

Nine states and 2 territories have funds to provide scholarship aid for both hospital and public health nurses for advanced work in orthopedic nursing or physical therapy

Seventeen states and one territory offer financial assistance only for the public health nurse who needs additional preparation in order to function on the crippled children's service

Seven states have no budget to provide scholarships for advanced work in orthopedic nursing.

Of the states which now have funds available for scholarships for hospital nurses, only four have thus far had applications for assistance. Some of the letters from states which have heretofore had no funds available for advanced orthopedic nursing preparation for nurses indicated that this item would be in their budget later; and some of the states which have offered assistance only to public health nurses indicated that consideration would be given to budgeting funds to assist hospital nurses to get desirable preparation.

No point would be served in listing the states offering scholarships since changes may occur as annual budgets are revised. It is suggested that a nurse who wishes financial assistance to enroll in an advanced orthopedic nursing program, and who expects to return to the state in which she resides, write for information to the crippled children services in that state.

The National Foundation for Infantile Paralysis educational program continues to provide scholarships for study in physical therapy. Many public health agencies with special programs for the orthopedic patient need nurses who also have preparation in physical therapy. The public health nurse interested in this type of service, who meets the prerequisites for admission to an approved school of physical therapy, may get further information regarding these scholarships by writing the Credential Secretary, National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York.

FEDERAL HEALTH AND WELFARE LEGISLATION
81st CONGRESS

Representing the ANA, Mrs. Eugenia K. Spalding on June 8 submitted testimony before the Senate Committee on Labor and Public Welfare on the need for federal aid to nursing education, and on the provisions for it as set forth in Senate Bill 1679, Title I. (See PHN, June 1949, p. 350.) This testimony was the result of the deliberations of the six national nursing organizations, of which the NOPHN is one, over nearly two years. (See summary of objectives, PHN, March 1949, p. 159.) Olwen Davies attended the hearings, representing NOPHN.

Pointing out that the nursing profession is convinced that financial aid is needed for nursing education in order to provide both the quantity and quality of nursing service needed regardless of the form of health legislation enacted, Mrs. Spalding emphasized the fact that the so-called shortage of nurses is not due to a decrease in available nurses but rather to an expansion in the needs. She listed the factors which account for the large gap between the supply and demand as:

1. Expansion of group hospitalization
2. Expansion of hospital facilities
3. Increase in the number of health agencies employing public health nurses
4. New developments in medical science and practice requiring more nursing services
5. Expansion of Army and Navy Nurse Corps
6. Increasing number of persons needing medical treatment and nursing care due to longer life span and complex conditions of modern living
7. International health obligations
8. Social and health legislation which will require nursing for implementation.

Not only more but better qualified nurses are needed, Mrs. Spalding said, including of course adequately prepared staff nurses but more particularly administrators, supervisors, and teachers comparable to the "teacher training" group in general education.

A study of available facilities in university schools offering advanced training has indicated emphatically the need for financial aid to improve now existing programs, to develop new programs, and to equip and construct new schools and expand present ones. University schools offering basic training, it was found, also required financial help. Of 1215 basic schools of nursing in this country, less than 8 percent are college- or university-controlled and offer training leading to a degree. This small group of some 100 schools bear a large share of the responsibility for the education of future leaders of the nursing profession. At a two-day conference of authorities on nursing education in December 1948 the urgency of expanding the facilities of university basic schools and establishing new ones was constantly stressed. It was recognized, however, that the needed growth cannot take place without adequate funds. In 1947 general student fees in universities and colleges met only 56 percent of total expenditures. Approximately 30 percent of the 56 was provided by federal payments to veterans. Without federal aid it is unlikely that universities or colleges will be in a position to initiate or expand basic programs for nurses.

Deliberate consideration, continued Mrs. Spalding, must also be given in any broad national health program to the problems of the hospital schools. Those schools which show promise should be given financial aid to improve and broaden their training, and conversely financial aid should be withheld from those who do not.

Student financial assistance is needed to secure the candidates needed in nursing. In 1946 total expense to the student in college- and university-controlled schools ranged from $50 in a state university to $3,135 in a private college, and it is a well known fact that educational fees have risen since then. The school in which students paid $3,100 for a

four-year program in 1946 reported the comparable cost in 1948 to be $4,625. It seems highly probable that more students would go to these schools were they financially able.

When a graduate nurse goes to a university to secure advanced training she is giving up the opportunity to earn for the period, and at the same time she is incurring educational expenses. Both college fees and living expenses are now at their all-time high. Many graduate nurses cannot afford a full-time advanced training program, even though they are capable of taking it and eager to do so. In the fall term of 1948 there were 11,600 students enrolled for advanced training programs—4,700 full-time, 6,900 part-time. It is a likely assumption that all or at least the majority would have been taking a full-time program, had they been able to give up earning during the period necessary to complete the university work.

Mrs. Spalding completed her testimony by pointing out the omission in Title I, S1679 of certain provisions believed by the nursing profession to be essential, and a number of inconsistencies and ambiguities in the language of the bill.

Housing Act of 1949

Already passed by the Senate, the bipartisan housing bill to establish national housing objectives and the policies to be followed in attaining them was, in the last week of June, under consideration by the House (HR4009). Major difference between S1070 and HR4009 is that the House bill would provide 1,050,000 public housing units over a 7-year period as compared with the 810,000 units in 6 years proposed by the Senate.

Chief provisions of S1070 are as follows:

Declared objective is that every American family should have a decent home and suitable living environment. It is recognized that private enterprise must be responsible for the major part of the job. Federal assistance is extended for slum clearance and for decent housing for low-income families in cities and rural areas to the extent such needs cannot be met by private enterprise.

Locally initiated, planned, and managed slum clearance programs are to be assisted by federal loans of 1 billion and federal capital grants of 500 million dollars over a 5-year period. The money is intended for the purpose of aid in securing and preparing land for reuse rather than for building construction on the land. The building of the public housing would be managed by local governments who would contract with private builders for the work of construction. The bill authorizes 810,000 units over a 6-year period.

Low-income families displaced by slum clearance would have preference for admission to the new public housing, and the rents charged, the bill provides, must be definitely lower than rents charged for decent private housing.

Provision is made for technical research and studies to promote the reduction in costs of housing construction and maintenance, and to promote greater production of housing.

Financial assistance is offered for improving farm housing by means of (1) loans to owners of self-sustaining farms (2) loans to owners of potentially self-sustaining farms and (3) small loans to sub-marginal non-self-sustaining farms for minor improvements.

There is to be a census of housing in 1950 and every 10 years thereafter.

Main opposition to the bill has concerned the public housing provisions. Proponents believe that private industry cannot provide housing at a price that lower-income families can pay. Opponents have pointed out that the past record of American industry has shown that industry can meet any need. Other arguments for and against have concerned questions of the competition of public housing with private industry; whether public housing is a matter which should be left to state and local governments to solve; whether the federal government is able to exert too much control over federally-aided projects; whether there should be a ban on racial segregation in the bill; and on the adequacy of the aid proposed for farmers.

If the House passes HR4009 with provisions differing from those in S1070, a compromise measure will be worked out by a joint House-Senate conference committee.

TRENDS IN MEDICINE AND PUBLIC HEALTH

CHILD MORTALITY FROM RHEUMATIC FEVER

There were 14,575 deaths from all forms of heart diseases among those under 20 years of age between 1939 and 1941, states George Wolff in "Childhood Mortality from Rheumatic Fever and Heart Diseases," published by the Children's Bureau. A minimum of 12,000 deaths was considered to be caused by acute rheumatic fever and its after effects. A comparison of leading causes of death in childhood and youth shows that among white children, deaths from rheumatic fever and heart disease hold an increasingly high place among fatal diseases as age advances; in nonwhite children tuberculosis is by far the greatest killer, especially among girls entering the childbearing age.

A comparison with mortality rates of earlier decades showed clearly that rates for heart diseases for white children were distinctly on the decrease. The decrease was less definite in nonwhite groups. Consistent difference in mortality rates between white and nonwhite children tended to show that rheumatic fever and heart diseases were unfavorably influenced by the adverse social and economic conditions of the nonwhite group.

Definite regional variations in mortality from acute rheumatic fever occurred as follows: Rates were below average in the South, while in the Northeast, especially in the Middle Atlantic area, rates were significantly above average.

In the Pacific region death rates were as low as in the South, while in the Mountain region rates were exceptionally high for white children in all age groups. The average death rate in all states was 11.7 per 100,000. This varied from 5.3 in Vermont to 22.4 in Utah.

The prospect for longevity in children with rheumatic fever was studied by Wilson and Lubschez (*Journal of A.M.A.*, November 13, 1948) who used the records of 1,042 children in the New York Area over a 30-year period, 1916 to 1947. It was found that the mean age at the onset of the disease was 6.5 years. The overall death rate was 14.7 per 1,000 per year. An afflicted child had 4 out of 5 chances to survive 15 years, 3 out of 4 to survive 20 years, and 2 out of 3 to survive 30 years after the onset of the disease. A child had a 50 percent chance to survive to the age of 40.

Acute rheumatic fever is not generally a reportable disease, yet to make any headway in combating this disease it must be reportable. The present difficulty in rheumatic heart disease control is the absence of good, simple preventive measures or specific methods of treatment. It is a problem for the entire community, and requires an attack similar to that employed against tuberculosis. Improvement in socio-economic factors should bring a notable decrease both in incidence and severity of the disease.

MORE MILK IN MENUS

Nutritionists are now recommending that adults consume three to four cups of milk a day rather than the pint a day formerly advised, since the Food and Nutrition Board of the National Research Council has increased the recommended daily allowance of calcium for adults by 25 percent.

Many adults refuse to drink even a pint of milk. Ways of increasing the "invisible milk," or milk in prepared dishes, are suggested in an article by Marie Balsley in the January 1949 *Journal of the American Dietetic Association*.

Encouraging the consumption of cereal and milk combinations is a promising means of increasing the milk furnished by prepared dishes. Bread, too, is capable of making a

contribution to the daily milk intake, although it is difficult to evaluate the amount of milk contributed by commercial brands. For those who do not drink enough milk as a beverage, it is possible to increase the amount of milk in the beverages they do drink. Children will readily drink reconsituted evaporated milk as a beverage with their school lunches. Another way of getting more milk in the diet is to serve almost any vegetable either creamed or scalloped. Many dishes featuring cheese have the advantage of furnishing milk nutrients from both milk and cheese. Most milk puddings, blanc mange, custard, and bread pudding, furnish about one-half cup of milk per serving, and certain pie fillings—butterscotch, pumpkin, and custard,—contain only a little less.

Milk supplies in this country are barely adequate for calcium needs, and in many sections, safe bottled milk is actually not available. The year-round availability of evaporated milk, its low cost and concentration, are good reasons for using to increase milk intake in the family diet.

BLACK WIDOW SPIDER BITE

Arachnidism, the syndrome following the bite of a black widow spider, is a definite entity in the field of general medicine. In the January 6, 1949 *New England Journal of Medicine*, Dr. W. E. R. Greer reports on symptoms and treatment.

The syndrome, as presented by 6 patients bitten by the black widow spider, observed in a 7-day period in an overseas tropical area, usually followed a similar pattern: transient excruciating local pain at the site of the bite; rapid local edema and redness of the skin; in 10 to 15 minutes a "burning sensation" that spread centrifugally from the site to the whole body; a sudden abdominal pain, often cramp-like as in an acute surgical condition of the abdomen; cramp-like pains in the legs, arms and back; a general feeling of "utter weakness;" restlessness and extreme fear reaction, often hysteria; headache, nausea and vomiting; and burning of the soles of the feet. In children, there may also be convulsions which are extremely difficult to control.

Patients in this series were given immediately 10 cc. of 10 percent calcium gluconate intravenously. Subsequently, they were given a saline infusion containing 10 cc. of 10 percent calcium gluconate. An ice bag was applied to the affected area. Relief was obtained in a short time in all cases, and was followed by a profound sleep. The patients were out of bed the next day and back on the job on the fourth.

Knowledge of the clinical entity is important since many spider victims are subjected to needless operations because the symptoms often simulate acute surgical conditions of the abdomen, such as appendicitis or peritonitis. Indeed the symptoms are referable to many systems of the body—nervous, cardiac, renal, pulmonary, and cutaneous manifestations may be present.

HOME ACCIDENTS

In a statement by the Home Conference of the National Safety Council, it is pointed out that accidents in the home are responsible for more deaths and injuries than any other accident classification. More than 30,000 people are killed and more than 5,000,000 injured every year in home accidents.

In considering what to do about this enormous toll, the Home Conference points to the recent policy declared by the Board of Directors of Nsc, "the size and complexity of the accident problem require the acceptance of responsibility not alone by individuals but by organizations and agencies."

The last few years have seen an aroused interest in safety on the part of official health departments, on the community, state, and national level. Home accident prevention has been by far the most important target of health department work in the field of safety. However, it is necessary for official health departments to expand their efforts in this field. The greatest success, concludes the Home Conference statement, can be achieved only through the cooperative and coordinated efforts of official agencies and of voluntary safety and health agencies working together. The Home Conference offers the ideal medium for achieving such coordination and cooperation in home accident prevention.

NEW BOOKS
AND OTHER PUBLICATIONS

YOUR BABY

By Gladys Denny Shultz and Lee Forrest Hill. New York, Doubleday & Company, 1948. 278 p. $3.50.

This book by two well qualified authors whose professional approach to the subject has been tempered by practical experience as parents and grandparents, brings a refreshing viewpoint to the subject. Starting with the prenatal period, the father is immediately given a definite place in the responsibilities and pleasures of the venture which is followed in detail through the preschool age.

Rather than laying down autocratic rules for "bringing up" baby, the book explains procedure for parents in helping baby reach his own optimal development. It avoids, however, the impression given by some of the newer child psychology treatises that the family is left at the mercy of baby's every whim. Training is stressed, but stressed at the times when baby shows he is ready for it according to his own cephalo-caudal law of development.

Throughout the book, reasons for babies' behavior at various ages and reasons why certain procedures are desirable are discussed. This should prove especially comforting to young parents in explaining baby's trying behavior during temporarily difficult stages of growth. Fluctuations in appetite are explained on a rational basis and the best way to handle these without disturbing baby's general pattern of good eating habits is shown.

While another section deals with baby's ailments and accidents, reliance on baby's own doctor is emphasized throughout. Immunization and well-baby check-ups are given their proper place.

All this information is presented in a delightfully readable chatty style which should prove very acceptable to young parents. A minimum of technical terms which might confuse them is used. Good marginal notes that assist in finding some pertinent statement for reference and a rather complete index add to the value of the book. Excellent photographs and drawings are interspersed throughout. A record section in the back offers space for the young parents to fill in baby's own personal history.

While especially written for parents, this book should also prove helpful to nurses as a guide in teaching the inexperienced young mother and father, especially in giving clear, simple explanations of the best procedures for baby's development. Somewhat disappointing to the nurse is the very brief reference to the development and care of the premature baby. Also, after following the mother so carefully through the antepartal period, her postpartal examination is dismissed with the most casual reference. Despite these few omissions this book should prove extremely valuable in helping establish a desirable pattern during prenatal, infant and preschool periods of development.

—LILLY HARMAN, *R.N., Director of Nurses, Dade County Health Unit, Miami, Florida.*

THE MACHINERY OF THE BODY

By Anton J. Carlson and Victor Johnson. Revised 1948. Chicago, University of Chicago Press, 1948. 639 p. $4.50.

Nurses, and all those whose primary interest lies in understanding human growth and development, are ever seeking new insight into individual behavior. We find these new insights in everyday contacts, in sociological and psychological studies. Too often we forget, in learning new approaches to human behavior,

that understanding does not grow merely from gaining knowledge of the effects of environment and of the effects of feelings and attitudes. We forget that many unrecognized and unfelt processes take place constantly within our bodies and help to determine our behavior. We forget that physiological processes, and the feelings that result from them, are integral parts of our behavior.

This text of physiological function is not new. In the 11 years since this book was first published, many additions have been made to our understanding of human physiology, all of which have been included in the 1948 edition. But—and this is most important to us as readers—in the 11 years since this book was first published, no writers have been able to surpass Dr. Carlson's and Dr. Johnson's approach to physiological function. Although complete and scholarly in its content, there are few readers, whether schooled in scientific terminology or not, who could not read, understand, and enjoy it.

This comment is not unique. It has been made before by laymen, students, and professional people. The authors remind us vividly of the reality of physiological functions and intensify our awareness of the manner in which functions affect human behavior. They help us to integrate physiological processes into our concept of human growth and development.

—Margaret Brooks, R.N., M.A., *Instructor in Health Education, University of Illinois.*

THERAPY THROUGH INTERVIEW

By Stanley G. Law. New York, McGraw-Hill, 1948. 313 p. $4.50.

Although this book is written primarily for physicians, it has value for anyone who works with emotionally disturbed people. The author's stress not only on therapy but also on the mature personality of the therapist seems especially important. His concept of treatment in which he emphasizes that the will to recover and the active role in therapy must come from the patient with the therapist imparting "the additional spark, the additional bit of insight," is well stated.

In discussing the therapeutic relationship, Dr. Law brings out the primary resistance on the part of the patient, his period of acceptance and dependence, and finally the separation and independence from the therapist. The six case studies illustrate therapy with patients with a variety of problems including psychosomatic disorders, a psychopathic personality, and behavior disorders in children in which both parents and children are treated in order to bring about a better family relationship.

—Spafford Ackerly, M.D., *Professor of Psychiatry, University of Louisville, School of Medicine, Louisville, Ky.*

RHEUMATIC FEVER—NURSING CARE IN PICTURES

By Sabra S. Sadler. Philadelphia, J. B. Lippincott, 1949. 151 p. $3.50.

While this new book is designed primarily for parents, it is a real contribution to all public health nurses and others concerned in the care of the rheumatic fever patient. The author has succeeded in presenting the latest concepts of the present-day treatment, including the physical, social, emotional, and mental. She presents the reader a well rounded view of what nursing care should be for children with rheumatic fever and at the same time indicates the services which the nurse may give to other members of the family.

The 204 illustrations have been prepared as a visual aid to parents and will supplement the teaching of the public health nurse in the home.

This book is timely because today there is such a widespread interest in the care of the rheumatic fever patient. While a nursing textbook is also essential, this is a valuable supplementary reference which should be available in cardiac clinics, pediatric wards, and libraries of public health nursing agencies.

—Eleanor Patricia Duffy, R.N., *Pediatric Nursing Consultant, Crippled Children Commission, New Jersey State Department of Health.*

A DOCTOR TALKS TO TEEN-AGERS

By William S. Sadler. St. Louis, C. V. Mosby, 1948. 379 p. $4.00.

In the present years when divorce and unsettled family affairs are so prevalent, it seems well to be able to make reverence to a book such as this one. Teen-agers, particular-

ly, do need help and guidance if mistakes are to be reduced.

Dr. Sadler, as a father and a consulting psychiatrist, writes from a wealth of practical experience gained through years of interviewing thousands of young men and young women. He closely scrutinizes and develops various topics,—heredity, eugenics, personality, religious concepts, morality, health, vocational selection, love, courtship and marriage.

Throughout the discussion there is a feeling of real sincerity and understanding of the problems and questionings of adolescents. A generous display of pertinent case histories clarifies points requiring emphasis.

Topical divisions within each chapter and paragraph headings make it possible for the reader to organize the subject matter presented throughout the book. Critically it might be considered too long for practical reading by teen-agers but interest would no doubt be maintained, in spite of the length, if the book were to be used in connection with a related class.

This book should be included in high school and college libraries. Both nurses and teachers might well use it as a reference for parents as well as teen-agers.

— ELSIE A. TABER, R.N., B.S., M.A., *School Nurse-Teacher, Poughkeepsie High School. Part-time Instructor in Education, New York University.*

GENERAL

PUBLIC HEALTH AND HYGIENE—A STUDENTS' MANUAL. By Charles F. Bolduan and Nils W. Bolduan. 4th edition. Philadelphia, W. B. Saunders. 1949. 423 p. $4.25.

PUBLIC HEALTH STATISTICS. By Marguerite F. Hall. 2nd edition. New York, Paul B. Hoeber, Inc. 1949. 441 p. $7.50.

TEXTBOOK OF PHARMACOLOGY FOR NURSES. By Margene O. Faddis and Joseph M. Hayman, Jr. 3rd edition. Philadelphia, J. B. Lippincott. 1949. 458 p. $3.50.

AMERICAN FOUNDATIONS AND THEIR FIELDS—VI. Edited by Wilmer S. Rich and Neva R. Deardorff. New York, Raymond Rich Associates. 1948. 284 p. $6.00. Sixth in a series of periodic surveys, this is an annotated and classified guide to 899 American foundations.

GIVER'S GUIDE TO NATIONAL PHILANTHROPIES, 1949-1950. National Information Bureau, Inc., 205 E. 42 Street, New York. 22 p. 10c.

NET CONTENTS STATEMENTS FOR CANNED FOOD LABELS. Revised 1949. National Canners Association, 1739 H Street N.W., Washington 6, D. C. 32 p. Single copies free.

LIBRARY KEY: AN AID IN USING BOOKS AND LIBRARIES. 7th edition. New York, H. W. Wilson Company. 1949. 149 p. 70c.

FIRST AID TEXTBOOK FOR JUNIORS. By Carl J. Potthoff. Philadelphia, Blakiston Company. 1949. 132 p. $1.00.

SHALL WE MAKE A SURVEY? 23 p. National Social Welfare Assembly, Inc., 1790 Broadway, New York 19. April 1949. Single copies 25c.

Contains questions to be considered before a survey is undertaken.

CHILD WELFARE

SOME SPECIAL PROBLEMS OF CHILDREN AGED 2 TO 5 YEARS. By Nina Ridenour and Isabel Johnson. 2nd edition. Published by the National Mental Health Foundation, Inc., 1520 Race Street, Philadelphia, in association with The New York Committee on Mental Hygiene, State Charities Aid Association. 1949. 72 p. 25c.

This pamphlet has been prepared to meet the expressed need of parents for helpful, practical guidance in meeting some of these frequent problems of normal children.

BEING A GOOD PARENT. By James L. Hymes, Jr. 52 p. Parent-Teacher Series. Bureau of Publications, Teachers College, Columbia University, N. Y. 1949. 60c.

This pamphlet aimed at helping parents and teachers to have a better understanding of their mutual concerns, and has many helpful hints for others working with children.

INFANT CARE

PREMATURE INFANTS—A MANUAL FOR PHYSICIANS. By Ethel C. Dunham, M.D. 401 p. Children's Bureau Publication No. 325. For sale by U. S. Government Printing Office, Washington 25, D. C. 1948. $1.25.

This book has been prepared to serve as a source of information in regard to prematurity and as a guide for the general care of the premature infant. Material from a wide variety of sources, with references for the convenience of those interested in more detailed study, has been brought together in compact form with a view to orienting the reader and providing a background for the clinical material.

FROM NOPHN HEADQUARTERS

HOUSING FOR 1950 BIENNIAL

The National Headquarters Biennial Nursing Convention Committee has decided that there will be no organization headquarters hotels named for the 1950 Biennial Nursing Convention, as in previous years, because San Francisco has many small hotels but very few of the larger type. A number of the hotels have semi-housekeeping apartments as well as the usual type of suites and rooms connected by baths.

The San Francisco Convention and Tourist Bureau will manage convention housing. They have suggested that better accommodations can be provided if those requesting reservations will not be too confining in stipulating the type of housing desired.

In this connection another suggestion was made, that is, that instead of the usual procedure of nurses requesting single rooms, that friends form groups and indicate to the Bureau the number of guests to be accommodated together with the price range desired. This will give the Bureau a greater latitude in which to work, and should result in a happier situation for those attending, through better quarters and reduced expenditures.

Application forms for hotel accommodations will be forwarded to the offices of all state nurses associations, SOPHN and state league presidents during the summer.

BIENNIAL PROGRAM COMMITTEES

The NOPHN Program Committee for the Biennial has been appointed, with members as follows: Florence Austin, Brooklyn, New York, chairman; Virginia Dontonville, Richmond, California; Helen F. Dunn, Augusta, Maine; Mable E. Grover, Columbus, Ohio; Anna McQuade, Washington, D. C.; Mrs. Eleanor Mosher, New York City; Jeanette Rosenstock, Pittsburgh, Pennsylvania; Mrs. Nova B. Young, Portland, Oregon; and Mrs. Elizabeth Fulcher, Atlanta, Georgia. NOPHN Section chairmen are also members of the committee: Mrs. Philip H. Salmon, Short Hills, New Jersey; Mrs. Pearl Parvin Coulter, Boulder, Colorado; Helen L. Fisk, Baltimore, Maryland; and Geraldine Hiller, Boston, Massachusetts. Ex-officio members are Ruth W. Hubbard, president, and Anna Fillmore, general director, of NOPHN.

The program committees of the three organizations sponsoring the Biennial will constitute the Joint Program Committee. Chairman of the NLNE Program Committee is Bernice E. Anderson, New Jersey, with Mrs. Dorrit D. Sledge, California, as co-chairman, ANA chairman is Clare Dennison, New York.

JOINT EDUCATIONAL ACTIVITIES

On June 1 announcement was made of the new name for the Brown Report Committee which will now be called the "National Committee for Improvement of Nursing Services." The change was made with the approval by referendum vote of the member boards of the Joint Board of the six national nursing organizations and reflects the broadened scope of the committee's interests. The committee has become a joint committee of the six organizations, administered as before by NLNE.

A second progress report by the chairman, Mary C. Connor (see PHN, April 1949, p. 224 for the first), summarizes committee activities up to May 25, 1949. Miss Connor states that so far outside funds have not been obtained to carry out the long-range program in regard to nursing education but there is reason to believe that the nursing organizations will assure support of the committee for the balance of the calendar year. The subcommittee on school data analysis is about ready to present its final report to the parent committee. Response to the school data analysis questionnaire, Miss Connor said, was remarkable, over 1,000 out of 1,186 schools having replied. Two new subcommittees are to be formed to expedite the service offered

by the committee—on advisory services to the schools, and on classification of programs of study for graduate nurses to carry out a project similar to that of the school data analysis subcommittee.

A second study guide on "Nursing for Expanded Health Services is Your Business" was prepared and sent to all state nursing organizations.

COMPULSORY HEALTH INSURANCE

Compulsory health insurance is currently of great interest to members of the general public, the medical and allied professions, and legislative bodies. NOPHN and ANA receive frequent requests for information as to how the organizations stand on the question. Accordingly the Committee on Nursing in Medical Care Plans of ANA and NOPHN has distributed to state nursing bodies the following expression of policy:

The American Nurses' Association and the National Organization for Public Health Nursing are concerned with the maintenance and improvement of programs and facilities for public health services and complete medical care for all the people of the United States. They believe that (1) the nursing profession exists primarily to serve the general public and is responsible for the provision of necessary nursing services to meet the needs of the public (2) good nursing service is one essential of any effective health program and should be as readily available as the medical services (3) governmental assistance is needed to make nursing services obtainable in all communities, rural and urban, and to people of all social and economic conditions, regardless of age, race, color and creed (4) the nurse, as a private citizen, has the right and privilege of supporting or opposing any medical care plan, whether voluntary or compulsory (5) the nursing profession should provide necessary nursing services in any medical care plan which is established and supported by the general public, provided the plan is established on sound business and actuarial principles. Non-participation is sanctioned when a plan does not contan safeguards to insure high quality of medical care.

ANA and NOPHN, as organizations, do not support or oppose legislation to establish compulsory health insurance. They do urge the expansion of health programs and medical services, including nursing service, to meet the needs of the public. They have sponsored and supported the following principles regarding medical care plans:

The expansion of medical care plans with all necessary nursing service, including nursing care in the home, should be encouraged.

In addition to voluntary effort, governmental assistance is necessary for attaining adequate distribution of health services. The consumer should decide what type or types of medical care plans, including insurance plans, should be encouraged.

MENTAL HEALTH ASSEMBLY

The World Federation for Mental Health will hold the Second Mental Health Assembly at Geneva, Switzerland, August 22-27, 1949. Ruth Taylor of the Children's Bureau will serve as the NOPHN representative, and Elizabeth Bracket of the Rockefeller Foundation as an observer.

NEW JONAS POLICY

At a recent meeting of the Advisory Committee it was recommended that free distribution of reprints and handbooks by the Joint Orthopedic Nursing Advisory Service to instructors and reference libraries be discontinued. Hereafter the cost as it is listed on the order form will be charged whether material is ordered by individual nurses or for use of instructors in teaching programs. Bills will not be sent for orders amounting to less than $1.00, and a remittance must accompany such order. As in the past slides and films will be loaned at no charge except for return transportation.

MORE 100% AGENCIES

Good for Minnesota! Ten county nursing services in this one state are included in this month's listing of agencies with 100% individual membership in the NOPHN. Good for Dubuque, Iowa, too, with two agencies listed in this one city—and for Mason City, Iowa, and Sioux Falls, South Dakota, also present and listed.

From Mason City Nan Clack writes that as far as she knows the Mason City School Nursing Service has always had 100% NOPHN membership. Hattie B. Lymenstahl, one of the staff members has been an NOPHNer since World War I and Miss Clack has been a member since she went into public health following that war. Congratulations to them both and to Ellen Glee Graves, the third member of their staff, who is helping maintain their fine record of membership.

IOWA

Dubuque—Division of School Nursing, Health Dept.
—Visiting Nurse Association
Mason City—School Nursing Service

MINNESOTA
Clay County Nursing Service
Crow Wing County Nursing Service
Kandiyohi County Nursing Service
LeSuer County Nursing Service
McLeod County Nursing Service
Pipestone County Nursing Service
Redwood County Nursing Service
Sherburne County Nursing Service
Sibley County Nursing Service
Steele County Nursing Service

SOUTH DAKOTA
Sioux Falls—City-County Health Department

CHANGE IN NOPHN WORK SCHEDULE

Beginning June 1, the NOPHN headquarters office will be open Monday through Friday, from 8:45 a.m. to 4:45 p.m. The office will be closed on Saturday except by special arrangement.

NOPHN FIELD SCHEDULE

Jean South leaves Denmark July 2, to observe nursing services in England until July 18.

Dorothy Rusby's Michigan trip in June included Bay City, Flint, Saginaw, Muskegon, Grand Rapids, Lansing, Ann Arbor, and Detroit.

Other recent NOPHN field trips, which were arranged after magazine publication deadlines included the following: Anna Fillmore—Washington, D. C.; Lucy Blair—Oklahoma City, Okla.; M. Olwen Davies—Boston, Mass., and Washington, D. C.—Helen Nelson—Portland, Me., and White Plains, N. Y.; Marie Swanson—Mt. Vernon, N. Y., and Pittsburgh, Pa.; and Louise M. Suchomel—Texas.

NEW REPRINTS

Reprints from the May magazine will soon be ready—"Nurse Midwifery Today" (10 cents), "Interview In School Nursing" (20 cents), and "Public Health Nurse In An Obstetrical Clinic" (15 cents). Single copies are free to members.

ABOUT PEOPLE YOU KNOW

Lucile Petry was sworn in on June 7 as an assistant surgeon general of the Public Health Service, the first woman ever to hold the office. . . . *Dorothy Wilson* will succeed *Elizabeth G. Fox,* who is retiring October 1, as executive director of the New Haven, Connecticut VNA. . . . The first award for "outstanding contribution to human welfare" made by the Indianapolis chapter of the American Association of Social Workers was given to *Mrs. Catherine Lory,* public health nurse. Mrs. Lory who is also a licensed midwife has for the last 10 years given outstanding service in rural areas of the state. . . .The Junior Red Cross Negro Council of Richmond, Virginia, has voted to change its name to the *Elizabeth Gaiters Council* in honor of the 20 years of service by Miss Gaiters in the Richmond Health Department and the fact she was among the first Negro public health nurses employed in the South. . . . Two American nurses were awarded the Florence Nightingale Medal at the annual American Red Cross meeting in June, for "distinguished service and great devotion to the sick and wounded in time of war and in time of peace,"—*Alta Elizabeth Dines,* recently retired as director of the Department of Educational Nursing of the Community Service Society, and *Mary M. Roberts,* recently retired as editor of the *American Journal of Nursing.* . . . The Nancy Vance Pin Award for outstanding service in the field of nursing was presented recently to *Mrs. Sabra Sadler* at the convention of the Graduate Nurses Association of Virginia. . . . *Beatrice Lott* has been named director of the Dallas, Texas VNA, succeeding *Mrs. Luriel S. Dakin* who served in that capacity for 13 years. . . . *Ruth Tuckey* formerly of VNSNY is the new executive director of the Community Nursing Service of Oak Park and River Forest, Illinois. . . . *Phyllis M. Dacey,* NOPHN charter member, has retired as executive director of the Kansas City, Missouri VNA after 28 years' service. . . . *Marie Lowe* is the new executive secretary of the Community Nursing Service of Winston-Salem, North Carolina. . . . *Carmen E. Frank* has joined the staff of the Social Hygiene Committee of the New York Tuberculosis and Health Association. . . . *Betsy Boylan* is finishing work in mental hygiene at Teachers College, Columbia University, and has been employed by the Metropolitan Life Insurance Company as a mental hygiene consultant. . . .*Mary Dunn* attended the 32nd annual meeting of the American Council on Education in Washington, D. C. as the NOPHN representative.

NEWS AND VIEWS

FROM FAR AND NEAR

WORK CONFERENCES OF THE NATIONAL NURSING ACCREDITING SERVICE

Plans are underway for three-day work conferences to be held in different parts of the country to explain the significance of the voluntary unified accrediting process undertaken by the profession through the National Nursing Accrediting Service. These conferences will be particularly helpful in acquainting the accrediting representatives already selected as well as in familiarizing potential representatives with the means available and the procedures and technics to be used in the process. All interested persons are most welcome. Arrangements will be made for an introductory meeting the first half day which will furnish general information about the accrediting program to all persons connected with nursing and the remainder of the three will be devoted to group study of various aspects of the procedure.

To facilitate the work of the National Nursing Accrediting Service the different types of educational programs in nursing have been classified into categories as: basic non-collegiate (or diploma), basic collegiate (degree), public health nursing and other programs for graduate nurses (supplementary and advanced). Educational programs for each category will be reviewed and evaluated by a special board of review and the accrediting representatives who make the actual survey will be selected because of their competence and interest in that special category. Surveys will be made by at least two nurses—accrediting representatives—one a full-time secretary from the National Nursing Accrediting Service and the other a regional representative who is well qualified and can be released from her regular position for a week for a survey which is requested in that area. No person would be asked to assist with a survey in the school from which she graduated or had been a recent faculty member or within the state where she is currently employed. Such accrediting representatives will be selected from faculty members of all categories and other nurses in the field of education. Since two of the fundamental purposes of accreditation are to assist those responsible for programs of nursing in providing better preparation of nurses and to encourage self-evaluation and study of problems in nursing, this plan of seeking assistance from regional faculties should be most beneficial. Directors or deans of nursing and their respective faculties will find the opportuniay to assist secretaries of the National Nursing Accrediting Service both stimulating and helpful in their own work. Because of the variety of categories and the time element which enters in, the names of large numbers of qualified accrediting representatives are necessary for the roster. Surveys are highly technical procedures which require understanding, sound objective judgments, and efficient planning so no time is wasted and the educational unit derives the greatest possible benefit from the visit. The purpose of these work conferences is to acquaint as many qualified nurses as possible with the philosophy and mechanics of the procedure so effective evaluations can be made.

The work conferences are to be held in cooperation with state leagues of nursing education. The four centers selected to serve the largest number of persons are:

New Orleans, La., August 2, 3 and 4
Denver, Col., August 9, 10 and 11
Chicago, Ill., August 16, 17 and 18
New York, N. Y., August 23, 24 and 25

A small registration fee will be charged.

It appears logical for each state to consider sending at least four representatives, one for each category. Expenses may be covered by the individual nurse, a school or other educational unit, or a local or state league. Good leaders will be present to assist with the discussions and group programs.

Anyone planning to attend the work conference should communicate immediately with National Nursing Accrediting Service, 234 West 56th Street, New York 19, N. Y., for details.

MANUAL FOR ACCREDITATION

The Joint Committee on Unification of Accrediting Activities approved, at its recent meeting, the release of a Manual of Accrediting in Nursing. This material should prove exceedingly helpful to those interested in any phase of nursing education since it covers the basic principles for all types of programs.

This manual will contain the Statement of Policy, Criteria of Excellence and Procedure for Guidance in Accrediting Educational Programs in Nursing, as well as special criteria in the areas of psychiatric nursing and mental hygiene and industrial nursing. In addition, will be included a bibliography of source materials, a glossary of terms, statement of fees, and the plan of the newly organized National Nursing Accrediting Service, 234 West 56th Street, New York 19, New York. Every school of nursing, every institution offering educational programs of nursing and every student of nursing will wish to have copies available.

HOME NURSING ON GUAM

Ellen Aird, assistant national director of home nursing, American Red Cross, recently returned from Guam where, at request of the U. S. Naval Government, she established an American Red Cross program of home nursing and hygiene in cooperation with the Public Health Department of Guam, for the Guamanian people to carry forward in the future.

Starting with the nucleus of a Guam Red Cross Chapter home nursing director and two professional nurses from the United States in residence there, Miss Aird first held a demonstration course with Girl Scouts as students, which also served largely as an instructor training course for the three nurses. These nurses then taught a second group of Girl Scouts before conducting classes for a group of 14 Guamanian nurses. From that point, the nurses, with Miss Aird, visited the 23 villages and 13 dispensaries of the island, observing the teaching and procedures of Guamanian nurses in their various village clinics, visiting many of the sick in their homes, and talking with numerous groups of Guamanians in the interest of future home nursing classes.

The Guam Red Cross Chapter Home Nursing chairman then organized a committee to recruit a potential non-nurse instructor in each village. Some of these are midwives, some are teachers or other interested persons willing to take the training course and to teach home nursing as volunteers in order to raise and maintain the standard of community health on the island.

The major health problems of Guam—all involving sanitation or hygiene—had been listed by the Navy as resulting from high incidence of tuberculosis, hook-worm disease, and infant mortality. In requesting Miss Aird to introduce the Red Cross Home Nursing program, the Public Health Department of Guam had stated two aims: (1) that mothers of children learn that supplementary feeding often is necessary for their infants, and that as soon as a child looks ill in any way, it should be taken for examination to the village clinic and (2) that people learn that tuberculosis is a communicable disease, and that by being around their loved ones, especially children, people with tuberculosis are doing the children harm; and that the people should learn to demand chest x-rays whenever they feel they have been exposed to tuberculosis.

By the time Miss Aird left Guam, eight classes in home nursing had been completed and eight more were underway.

ACNS ELECTIONS

Elections for the principal offices of the Association of Collegiate Schools of Nursing were held recently. Elizabeth S. Bixler, Dean of the Yale University School of Nursing, and

Mrs. Dorothy Williams, Western Reserve University, were retained as president and executive secretary respectively. Julia Hereford was elected vice-president, Irene Carn, secretary, and Virginia Dunbar, member of the board of directors.

● The U. S. Civil Service Commission has announced an examination for nursing consultant, for filling positions paying salaries ranging from $4,479 to $7,432 a year. The positions are in the specialized fields of public health, maternity, orthopedics, pediatrics, and psychiatry.

Applicants must have completed a full 3-year course in an approved school of nursing or a full 2-year nursing course plus additional appropriate nursing experience or education. In addition, they must have had specialized experience and education pertinent to the type of nursing consultant position for which they are applying. No written test is required. Age limits, waived for persons entitled to veteran preference, are from 18 to 62.

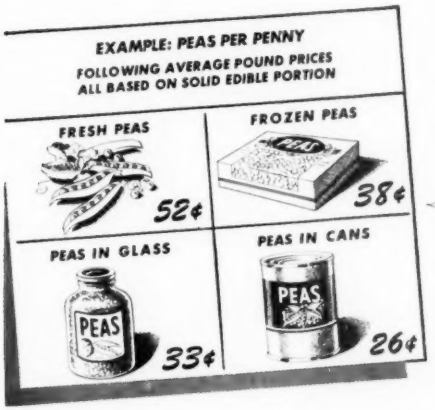
Interested persons may obtain further information and application forms by writing directly to the U. S. Civil Service Commission, Washington 25, D. C. Applications will be accepted in the Commission's Washington office until further notice.

● The Department of Nursing of Louisiana State University announces a 6-weeks' course of instruction and clinical experience in the care of premature infants, for registered graduate nurses. The course will be given at 2-month intervals. The present course began June 6. Applications should be addressed to the Director, Department of Nursing Education, 1542 Tulane Avenue, New Orleans 12, La.

● The two-day celebration, May 20-21, 1949, of the 50th anniversary of the Hotel Dieu School of Nursing, New Orleans, was highlighted by the convocation in Labouré Hall auditorium. Ella Best, executive secretary of ANA, was guest speaker.

Research shows how your patients can have good food at less cost

Full-year field check by 19 Universities* establishes significant data on food costs. Study compares COSTS AND AVAILABILITY of 12 commonly used Fruits and Vegetables in their four marketable forms—Fresh, Frozen, in Glass and in Cans.



In these days of high prices, don't people seeking your guidance constantly ask: "How can I get more food value for my food dollar?"

19 leading American universities sought the answer in a 12-months' research project—October, 1946 through September, 1947. The results of this comprehensive study on the 12 fruits and vegetables boil down to this: *Penny for penny, canned foods in general give consumers more food for their money, as well as more nutritional values. Most foods in cans cost less than the same foods in glass—less than fresh foods—and far less than frozen foods.*

SOUND RECOMMENDATION

As you yourself know, no matter how good a particular food may be nutritionally, if it is not readily available, or if the price is high—that food is of little practical value. Therefore, the known nutritional values of food in cans, plus the *high* percentage of year-round availability and the *low* cost of canned foods in general, are a really winning combination.

Results of this coast-to-coast research again demonstrate how important canned foods are in relation to improved national nutrition. Their variety, their convenience for storage and use, together with their availability and economy, constitute a sound basis, we believe, for your recommending this solution to today's high cost of living.

FREE ***booklet giving full details of Comparative Cost and Availability Study.***

Please send me, free of charge._____copies of the new booklet entitled: "Canned Foods in the Economic Spotlight." O

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*For full details see "Comparative Cost and Availability of Canned, Glassed, Frozen, and Fresh Fruits and Vegetables" in the April issue of the *Journal of the American Dietetic Assn.*

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Now you can have those well-groomed hands *On Duty* as well as *Off Duty*—in spite of the drying damage of frequent scrubbings, soap and water.

with TRUSHAY that is

For TRUSHAY starts off by being the most luxurious softener that ever smoothed your skin—rich as cream—but without a trace of stickiness. It's sheer delight to use at any time.

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For TRUSHAY does double duty with its unique "beforehand" extra. Smoothed on *before* frequent washings, TRUSHAY protects your hands even in hot, soapy water—guards the skin by helping to preserve its natural lubricants.

Begin today to use TRUSHAY *—and when patients admire your well-groomed hands, tell them about the lotion with the "beforehand" extra,* TRUSHAY.

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For instance, your crisp clean uniform and your air of confident grooming go a long way to brighten your patient's day.

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MUM is the safer way to preserve morning bath freshness. You'll love its delightful new floral odor, its creamy texture. And MUM is sure because it prevents underarm odor throughout the day or evening. Recommend it to your patients too.

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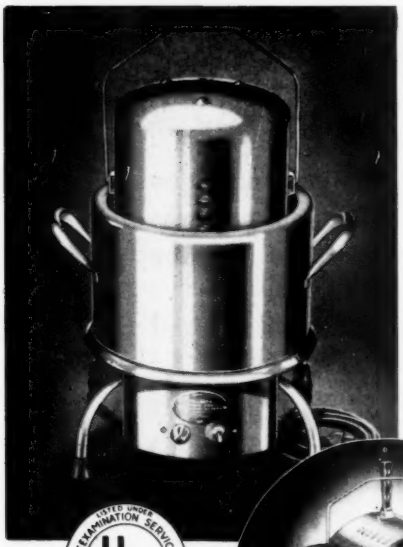
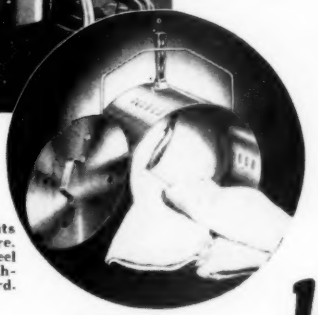


Now—*for the first time*—visiting nurses can easily administer efficient hot-pack therapy to patients *in their homes*. Can combat the crippling effect of poliomyelitis by continuing treatment started while the afflicted were confined in hospitals! The new, *portable* Vollrath Polio-Pak Heater enables you to bring into any electrically wired home the same safe, simple method of preparing hot packs in quantity as Vollrath's proven hospital unit.

Vollrath's *portable* is a complete unit, simple to operate without tedious, time-consuming training or heavy expense. A nurse can prepare fifteen 12″ x 24″ double-thick hot packs—or equivalent—*at one time*. Can prepare and apply packs at patient's bedside—without fuss, needless labor, or loss of time.

Made of polished Stainless Steel, with no moving parts to wear out, the Vollrath *Portable* Polio-Pak Heater is built for years of service. Prompt delivery!



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MEAT...

And This Protein Era

"Today we are in the protein era."* This terse but meaningful statement, made by an outstanding authority in a recent review on the progress of nutrition, reflects an accomplishment of utmost significance.

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The therapeutic use of a high protein dietary has revolutionized the prognostic outlook in many hepatic diseases formerly considered resistant to treatment.

The use of high protein dietaries has resulted in a gratifying reduction of surgical morbidity and mortality, made possible by systematic presurgical nutritional build-up of the patient. Through this same approach, wound healing and general recovery are greatly promoted.

In nephritis and nephrosis, at one time considered absolute contraindications for animal protein in the dietary, the use of protein in liberal amounts can significantly reduce mortality and decidedly improve the clinical condition.

The benefits derived from high-protein nutrition in pregnancy and lactation are diversified and far-reaching, embracing both mother and offspring. For this reason, a generous extra serving of meat, given daily as a routine measure, has been strongly recommended as a means of improving the health of mother and child.

Meat is rightfully regarded as an outstanding protein source. It is notably rich in protein. The protein of meat is biologically complete, capable of satisfying all protein needs of the body from childhood to old age. And, particularly important in disease, the excellent digestibility of meat gives virtual assurance that its protein and other valuable nutrients become available for utilization.

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

POSITIONS AVAILABLE

WANTED—Public health nurses and educational director for well established generalized program, including school health, in Columbus, capital city of Ohio. Combination agency—Department of Health and Instructive District Nursing Association. Population, 350,000. Present salary for staff nurses, $215 per month, for nurses without preparation in public health nursing, with higher salary based on preparation and experience. Probable general increase in salaries fairly soon. Travel allowance 8c per mile. Vacation and sick leave, 2 weeks each; all legal holidays free; 38½ hour week. Educational director's salary open. Apply: Instructive District Nursing Association, Room 405, City Hall, Columbus, Ohio.

WANTED—Experienced public health nurse for staff position involving some supervision in a District Health Department under district supervision. Salary commensurate with position. Generous car allowance. Write: Dr. M. B. H. Michal, District Health Officer, Waynesville, N. C.

WANTED—Senior public health nurse—openings in one nurse services, some on itinerant basis. Starting salary $4,620-$5,313, depending on area to which assigned; annual increase of $180. Public health training, minimum 2 years supervised experience in generalized program, and excellent references required. Thirty working days annual leave, 2 weeks sick leave, workmen's compensation and retirement plan. Application blanks and details available from Alaska Department of Health, Juneau, Alaska.

WANTED—Public health nursing supervisor. Beginning salary $4,980-$6,072. Public health training, undergraduate degree, supervisory experience in generalized program and excellent references required. Leaves and other benefits as outlined for senior nurses. Application blanks and details available from Alaska Department of Health, Juneau, Alaska.

WANTED—Qualified public health nurse for attractive rural areas on coast of northern California. Generalized public health program. Population 60,000; state retirement plan; car furnished. Starting salary $3,200. Apply: Director, Humboldt County Department of Public Health, 805 Sixth Street, Eureka, California.

WANTED—Public health supervisor. Vacancy in City Health Department. Generalized nursing program; travel allowance; bachelor of science degree with a major in public health nursing. State beginning salary. Apply: Dr. S. J. Stangel, 709 Washington Street, Manitowoc, Wisconsin.

WANTED—Two public health nurses for staff positions in general public health program in new and enlarging health department in interesting county in Southeastern Michigan. Close to two large University teaching centers in public health nursing. Salary based on public health experience and training. County pension plan; vacation and generous sick leave policy. Must have automobile; mileage furnished. Apply: Director, Macomb County Health Department, County Building, Mt. Clemens, Michigan.

WANTED—Public health nurses to fill vacancies in Health Department. Generalized service including maternal and child care, school health and communicable disease control. Immediate appointment on provisional basis. Starting salary $2400; 37 hour week; liberal vacation allowance; in-service training. Write: Bureau of Nursing, City Health Department, 125 Worth Street, New York 13, N. Y.

WANTED—Two staff nurses for generalized program in a combined agency—health department and bedside nursing functions. Maternal and child health supervision; communicable disease, tuberculosis and parochial school nursing. Salary based on qualifications and experience. At least one year public health nursing course required, degree and experience preferred. Forty hour week, one month vacation, sick leave, state retirement plan. Write: Director, Montclair Public Health Nursing Service, 65 Chestnut Street, Montclair, N. J.

WANTED—Nurse with public health training. Rural Connecticut—one nurse agency near larger cities—good board and personnel policies. Salary $2,700-$2,800. Apply: Box DC, NOPHN, 1790 Broadway, New York 19, N. Y.

WANTED— Qualified supervising public health nurse for attractive rural area on coast of Northern California. Generalized public health program. County population, 60,000, headquarters town, 22,000. State retirement plan; staff of six public health nurses; car furnished; starting salary $4,080. Apply: Director, Humboldt County Department of Public Health, 805 Sixth Street, Eureka, California.

WANTED — September — Educational Supervisor. Generalized program. Graduate affiliation with university program. Degree and experience in supervision required. Staff of 20 nurses; 40 hours; 5 day week; annual vacation—22 working days; sick leave; retirement plan; salary open. Apply: Miss Ruth B. Wood, Director, Visiting Nurse Association of Newark, 119 Ridge Street, Newark, New Jersey.

WANTED—Public health nurses for positions on all levels in urban and rural agencies, official and private, in various parts of the country. No fee. Apply in person or write to Nurse Counseling and Placement Office, New York State Employment Service, 119 West 57th Street, New York 19, N. Y.

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